Mid Hudson RPC Board Meeting
March 13, 2019
10:00-12:00
RSS, Goshen, NY

Welcome & Introductions

- Meeting called to order 10:07 by Marcie Colon.
- Introductions made by board members and gallery.

Approval of Minutes from December Meeting

- Motion made by Angela Vidile to accept minutes into record; seconded by Susan Miller. Minutes from December meeting will be added to CLMHD website.

Annual Report – 2019 Goals

- Marcie would like to have an open discussion about how the RPC is doing. Thank you to all who responded to the RPC survey. The survey said most board members agree there are significant benefits to meetings, agreed agendas were appropriate, and that activity was positive.
- One suggestion was getting more feedback from state on various issues. Marcie thinks this is appropriate and working to do that. Marcie has begun quarterly meetings w OMH field office, and Victoria DeSimone will give update today.
- What else can we share about what is going well, and what we would like to do better?
    - Comment made that the n person board meetings are appreciated (better than over phone.) Marcie: This is why no call in numbers for board meetings. Ideally committee meetings as well, but we recognize people travel great distance.
    - Any other comments – please reach out directly to Marcie any time.

Board Elections

- Two open board seats have been filled: Nadia Allen and Joan Crawford.
- One peer seat was open; now have one more candidate Jeffrey Zitosfky; Marcie will reach out this week.

BHCC Update

- Susan Miller introduced speaker Richard Tuten, CEO of Coordinated Behavioral Health Services IPA, LLC. Richard's has experience in IPAs and managed care, and is also an attorney and respiratory therapist.
- Richard has also worked outside of NYS (Florida), providing a unique perspective and an appreciation for New York's progressive bent toward integrated health.
- Richard's PPT will be shared. His BHCC presentation focused on:
    - Background – Provided $60M over 3 years in form of 19 awards.

- Deliverables – Create organization, networks to address full continuum of care, achieve sustainability beyond BHCC funding period.
- Data – Assessing IT capabilities of network providers, and collecting/analyzing wide variety of data.
- Quality oversight – Develop, implement, and monitor quality metrics.
- Clinical integration - Develop and implement clinical protocols and standards. (Difficult to get physicians to all do something the same way! But when they get together to talk, find there are more commonalities than not. And where there are differences, we can look at outcomes and see where protocols may need to change.
- History – CBHS grew steadily in membership, then joined with CCH, another IPA (both had received BHCC funds). Total membership is now 31 agencies. Fidelis is oversight MCO. Ultimate goal is sustainability; CBHS is for-profit and carries financial risk for individual members. CBHS received $2.7M; CCH received $2.4M. For reference, $5M was highest award statewide.
- Organization
  - Class A – full membership
  - Class B – 50% risk
  - Class C – Part of CCH IPA
- Personnel
- Key Services
- Social Determinants
- What does CBHS IPA do?
  - 2 types of healthcare professionals. Group 1 takes care of clients; Group 2 takes care of Group 1. CBHS is Group 2. CBHS doesn't do direct care. Functions as team of care providers. Can amplify services of any single agency and facilitate care communication.
  - Sets and monitors quality measures.
  - Provides single source contracting.
  - Neutral forum for members to discuss issues (using care not to become "anti-competitive".)
  - Credentials agencies & providers
- Future collaboration:
  - Payers
  - Integrated delivery networks
  - Providers
  - Peers
  - LGUs
  - State agencies
  - Community input – how can we help you?

Feedback:

- Stephanie Marquesano: How do you foster integrated treatment in support of co-occurring efforts? Are you willing to participate in truly integrated Systems of Care? Richard and Mark: Yes – we are working with Health Homes, making sure peer services represented in our membership, including OASAS agencies, FQHCs, hospitals for integrative care. Always looking for additional ways and happy to have further dialogue.
- Darcie Miller: It's time for DCSs to put out integrated care plans; suggest get input from members of community service boards.

- Dani Heifetz (Fidelis): We need to ensure we're including medical/physical integration too; with VBP many plans starting with total cost of care, so we want to identify opportunities not just for referrals but that bloodwork, prescriptions, side effects are being tracked.
- Perryn Dutiger: What are the key metrics in VBP? Richard: We started with just three: 7-day follow up after psych hospitalization, follow up after ED visit for alcohol or SUD, and diabetes screening/monitoring for people with bipolar or schizophrenia diagnosis. Wanted MH, SUD, PH all represented, and to encourage systems to communicate and form relationships between providers. Other BHCCs using a plethora of other metrics. Susan Miller: it was a long process.
- Marge Stuckle: I see some members are members of other IPAs. How is this working? Is there sharing? We have RHIOs, PSYKES, and BHCCs… can you speak to coordination across the region? Richard: Mark is working to get more clarity on contracting, but the contract tells us the service area. Arms Acres Liberty Management for example has large reach, as far down as Long Island, but the one in Carmel is with us.

Co-Occurring SOC Update - Stephanie Marquesano

- On macro level, we have been able to do a deep dive county by county, and participated in Australia conference – very peer driven.
- Westchester – co-occurring SOC committee – was at 30 individuals on the committee which has since increased, –looking to ensure terms of prevention, Youth Summit – of 49 high schools in the county, Montefiore – paying for youth summit, breakout groups include sports, arts, mindfulness, civic engagement, 90 second elevator pitch
- Harris project – 5 years into the project which now should be branded - logo represents duality
- Putnam – smaller steering community – Allison will reach out to Mike to discuss youth summit in the county. Have probation, dept. of corrections, exciting
- Some of the events and activities:
    - Presented to Ulster BOCES
    - Victoria Australia – we've never thought about prevention
    - What's important for me- reflective of what looking for- will be trained in how to deliver at their schools
    - Orange County – forerunner (shout out to Darcie Miller)
    - Melissa Stickle DCS in Sullivan their project has been titled - United Sullivan
    - Marcie – it's a broad topic, looking to bring it back to RPC focus which is Medicaid transformation
    - Stephanie had presented an abstract NYS Pub Health Association – May hot topic
    - Ken Minkoff submitted abstract too
    - Welcome Orange, Ken Dani from Fidelis shared that they have moved in direction of changing the way we respond to crisis in Orange County – help line → co-location collaboration approach, doing all the assessments which is exciting and bridged a gap co-locating w 911 center. Sophisticated tracking – exciting time for Orange County
    - Darcie requested Stephanie share youth summit info
    - Want to get MCOs involved, include the billing piece

DSRIP Update – Ed McGill of WMC Health PPS

- DSRIP officially ends March 2020. Work will continue through then, although some reporting after that.
- State is also talking now about some of unearned DSRIP funds. (Original waiver was $8B; $6B was used to fund PPSs. Over course of 5 years, now think will be less than that, between

$550M- $1B. Some other states are going back to CMS to get extensions of waivers. For NYS, it's uncertain – Ed has heard everything from 1-6 years. With current federal government administration, 1 year is more likely – but 2020 election could change that. The point is that the work needs to continue, and State is talking to PPSs, various associations – and the idea is to replicate and scale throughout the state the projects that have worked. Follow up after discharge was a big item measured. Preventable readmissions are going down. Big item of discussion was tying in with VBP: VBP technically was supposed to be the vehicle/catalyst by which initiatives were pushed forward. This hasn't happened fast enough – this is why we need extension.

OMH Field Office Update – Victoria DeSimone

- Children's transition – a number of memos have been sent out regarding NPI numbers and timeline.
- Adult HCBS: All are concerned about implementation and low utilization and identifying barriers. Barbara from OMH shared latest HHH numbers, indicating large drop in number from eligible members to actual paid claims. This conversation led into:

HHH Update/Discussion

- Amie Parikh:
  - Care Managers say large HCBS barrier is that contacts listed on OMH provider list includes C-level administrative contact, not referral contact.
  - Also, we have a "chicken and egg" situation: providers are not getting referrals, so – we're not getting referrals so they can't build their HCBS program; there's no money to build the infrastructure. Eligibility has shot up: 75% in Health Homes; DOH 100%. But why should members and CMAs go through 45-60 minute assessment when can't access services?
  - Waitlist for peer services is a statewide issue. Can we consider reimbursement rate for peer services as issue for RPC this year?
- Marcie: This is a big conversation, and one being addressed at HHH. And reminder when we looked at issues as a region, peer services wait list was one of them but was *not* prioritized by the group. If we want to revisit that we can discuss at HHH.
- Need to look at actual cost of HCBS, including overhead and travel.
- Some HCBS providers are still asking lead HH how to bill. May be time to review MCTAC trainings. Marcie will distribute info, and possibility of road show series of trainings.
- Cathy Pandekasas: We knew HCBS billing would be an issue, so we hired a consultant to make sure we got paid – we knew they understood how to do clean claims.
- Josh Gran: MCTAC resources were helpful, and everyone was ready 3 years ago. Then staff turned over and priorities shifted when there were no referrals! So may need to invigorate.
  - Response: CPI is doing some trainings

Children & Family Subcommittee - conversation deferred to next meeting

Peer/Family/Youth Stakeholder Group - Josh Gran

- Working on collecting feedback/grass roots reflections on Medicaid redesign from customers/users – those engaged or disengaged with system. 2 simultaneous efforts: broad based focus groups as well as survey.
  - Trying to get at what Medicaid redesign is at its core, and how we can improve it. Looking in particular at original goals and strategies of NYS MRT: HH, Triple Aim, Integration (i.e. Have you ever had your MH/SUD/PH needs addressed simultaneously?), FFS vs. VBP (i.e. If money were

spent not in support of you being sick, but toward health outcomes, what would that look like? Self-directed care?)
  - Would like to go to established groups i.e. PROS where people are already engaged, but also where they may not be i.e. shelters, EDs, FQHCs, warming stations. For shelters, will need to go in evenings, and now while it is cold.
  - Marcie: WE HAVE A FABULOUS PEER GROUP!

Clinic Sustainability Taskforce

- Marcie: This issue was not ready to present to state partners on November 30, but that has worked in our favor - we got longer, and more direct access to State. Next follow up will be in 2 weeks.
- Group has included: Dean Scher, Amy Anderson-Winchel, Mark Sasvary, Melissa Stickle, Tom Quinn, Susan Miller and Marcie Colon
- Concern is that clinics that serve people w complex needs will be sustained over long haul because lots of changes put in jeopardy. Marcie will send out issue statement again.
- Requests include: IN OASAS clinics, treatment plan require psychiatrist or LCSW, but OMH requires psychiatrist; request is that LCSW can sign off on OMH clinics. We know this is a CMS rule, so we're looking at what State would need to go to CMS and request that change.
- Q: Do new telehealth regulations impact article 31s? A: Potentially – comment period is closed on new regs. Crystal Run Healthcare stopped telehealth due to sustainability. Other agency found that half of visits were for non-psych issues; more social determinants health, not used the way intended. WMCHealth continues using telepsychiatry.

Monthly DCS Meeting

- Marcie has monthly meeting with Mid Hudson DCSs. At most recent meeting, DSSs and HH leads were invited to identify barriers enrolling in HH.
- Conversation about role of children's SPOA, and how if children get to HH first, they should be referred to SPOA for wraparound services.
- Darcie Miller suggested we also need to look at foster kids. Reach out to DSS, look at trauma, most would qualify for HHCM. These children deserve as much support as can get.
- Crystal Run Healthcare request: At state level, can we get some transparency as to what exactly are hang-ups with CMS process for children's transition. It would help providers (and some MCOs) with staffing decisions. Fidelis agrees – makes hard to know about hiring.
- Darcie – discussion ACE and plug for Resiliency film.
- Marcie: OPWDD not represented, but would be welcome at table.
- Early intervention: 0-3 actually is supposed to be handled by children HH, but no one's doing it because it doesn't make sense. Takes a certain expertise.

Board Meeting Dates – 2019

  - June 12, 2019,
    Rehabilitation Support Services
    30 Matthews Street, Suite 204 Goshen
  - September 11, 2019
    Dutchess County Dept. of Behavioral & Community Health
    230 North Road, Poughkeepsie

- December 11. 2019
  Dutchess County Dept. of Behavioral & Community Health
  230 North Road, Poughkeepsie