REGIONAL PLANNING CONSORTIUMS

Southern Tier

DECEMBER STAKEHOLDER MEETING

REGIONAL PLANNING CONSORTIUMS
GOALS FOR THIS MEETING

- **Update on Medicaid Managed Care Implementation**
- **RPC Highlights: function, purpose, support & board composition**
- **Review Election Mechanics, Board Requirements & Components of the RPC Co-Chairs Meeting**
- **Attendee Networking (~ 15 minutes)**
- **Unveil the Southern Tier RPC Board Nominees** ***(by stakeholder group and county)***
- **Breakout Groups (CBO's, Peers/Family, Hospitals & Health Systems Providers, Key Partners, MCO's) Reconvene for Next Steps**

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REGIONAL PLANNING CONSORTIUMS

(UPDATE ON MEDICAID MANAGED CARE IMPLEMENTATION)

Melissa Staats – NYS OMH

Bureau of Stakeholder Engagement

1. Enrollment

HARP Enrollment (Capitation payments to MCOs)

HARP Enrollment with Capitation Paid as of 2016-11-03	
NYC or ROS	Enrollment with Capitation
NYC	44,400
ROS	34,794
Total	79,194

HARP Opt-outs (Enrollment Broker Reported) ROS and NYC

HARP Opt Out By Reason			
OPT-OUT REASON	REASON DESCRIPTION	CUMULATIVE TOTAL	
		NYC	ROS
16	I do not need the additional services that HARP	**14%**	**24%**
17	I do not understand what a HARP is	**0%**	**1%**
18	Gains eligibility for other specialty plan	**0%**	**0%**
19	Consumer choice; no reason provided	**13%**	**11%**
22	Prior care relationship	**1%**	**10%**
23	I do not want to be identified/labeled with special	**0%**	**0%**
20	Transfer/Disenroll out of HARP	**70%**	**53%**

1. Claims Monitoring

Plan Reported Claim Denials ROS 7-1-2016 through 11-7-2016

MH & SUD Claims Stats				
Plan name	Total Claims	Total Pended Claims	Total Paid Claims	Total Denied Claims
Plan 1	43,106	0%	79%	21%
Plan 2	565	2%	97%	3%
Plan 3	42,610	4%	87%	9%
Plan 4	203	0%	77%	23%
Plan 5	26,137	13%	66%	22%
Plan 6	99,956	0%	97%	3%
Plan 7	390,419	0%	93%	7%
Plan 8*	249,154	2%	83%	15%
Plan 9	10,935	5%	96%	3%
Plan 10	61,814	0%	60%	40%
Plan 11	136,741	0%	64%	36%
Plan 12	29,885	1%	79%	20%
Plan 13	68,843	10%	71%	20%
Plan 14	3,932	11%	77%	12%
Plan 15	43,865	0%	51%	49%
Total (07/01/2016-11/07/2016)	1,208,165	1.6%	81.7%	16.7%
Last Report (07/01/2016-10/24//2016)	1,036,522	1.9%	82.2%	16.0%

FFS Comparison ROS 7-1-2016 through 11-7-2016

ROS Current claims vol. vs. Historical FFS baseline (Jul. 01-Nov. 07)								
Service Type	ACT	CDT	CLINIC	Inpatient & CPEP	IPRT	PH	PROS	Total
Plan reported Vol. (2016)	931	3,169	304,725	4,447	6	726	9,872	323,876
Historical Baseline (2015)	2,197	13,571	282,889	10,019	123	3,306	21,128	333,233
Plan reported vol. as % of Baseline	42%	23%	108%	44%	5%	22%	47%	97%
Notes:								
· *Clinic and Inpatient baseline include FFS claims and Encounters.*								
· *One health plans are excluded for this comparison because of data integrity issue.*								

FFS Comparison NYC 10-1-2016 through 11-7-2016

NYC Current claims vol. vs. Historical FFS baseline (Oct. 01-Nov. 07)								
Service Type	ACT	CDT	CLINIC	Inpatient & CPEP	IPRT	PH	PROS	Total
Plan reported Volume	9,998	53,728	1,507,196	19,466	2,389	2,499	23,925	1,593,107
Historical Baseline	16,688	114,509	1,506,805	46,249	5,191	13,499	42,648	1,703,693
Plan reported vol. as % of Baseline	60%	47%	100%	42%	46%	19%	56%	94%
Notes:								
• *Clinic and Inpatient baseline include FFS claims and Encounters.*								

Note: Data has been corrected to adjust for previously incorrect submissions from 1 plan.

Assessment Data NYC as of 11-3-2016 – Based on claims lag

HCBS Claims from MDW (OMH View) as of 2016-11-23		
Row Labels	**Claims Vol.**	**Unique Recipients**
Assessment	**1,599**	**1,518**
HCBS Brief Assessment	1,218	1,179
HCBS Full Assessment	381	339
HCBS Service	**482**	**85**
Short-term Crisis Respite	379	52
Peer Support	38	9
Psychosocial Rehab	20	7
Education Support Services	16	8
Pre-vocational	13	4
Residential Supports Services	12	2
Intensive Supported Employment	2	1
Transitional Employment	2	2
POC	**1**	**1**
Plan of Care Development-Initial	1	1

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REGIONAL PLANNING CONSORTIUMS

(REVISIT - WHAT IS AN RPC?)

(Cindy Heaney, LCSWR, CASAC, Director of Mental Hygiene, Southern Tier)

NEW YORK STATE CONFERENCE OF LOCAL MENTAL HYGIENE DIRECTORS (DCS Introductions)

Statewide organization – Directors of Community Services (DCS) of the 58 Local Governmental Units (LGU's) in the state.

Each county has a DCS, you may also know them as your:

County Commissioner of Mental Health or County Mental Health Director

Under MHL, the County Director of Mental Health oversees, manages and plans for services and supports for adults and children with mental illness, substance use disorders and/or developmental disabilities in their LGUs.

BEHAVIORAL HEALTH TRANSITION TO MEDICAID MANAGED CARE

- **Adults in Mainstream Managed Care Plans:** All adult recipients who are eligible for Medicaid Managed Care will receive the full physical and behavioral health benefit through managed care.

- **Children in Mainstream MCOs:** Children´s behavioral health services, including all six home and community based service (HCBS) waivers currently operated by OMH, DOH and OCFS, will be included in the Medicaid Managed Care benefit package in 2018.

The goals of the *transition are to improve clinical and recovery outcomes for participants with SMI and/or SUDs; reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and increase network capacity* to deliver community-based recovery-oriented services and supports.

REGIONAL PLANNING CONSORTIUM

A Regional Planning Consortium (RPC) is a regional board populated with community-based providers, peers/family/youth, county mental health directors, regional healthcare entities and managed care companies from each region.

There will be 1 RPC in each of the 11 regions across New York State.

FOUNDATION: Each region will experience unique challenges and opportunities as the behavioral health transition to managed care occurs. These challenges require in person dialogue and collaboration to resolve.

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RPC AUTHORITY & SUPPORT

AUTHORITY: The Regional Planning Consortiums derive their authority from the CMS 1115 Waiver with New York State. The 1115 Waiver application describes to CMS how NY intends to implement the HARP program and the RPC is a component of the waiver application that was approved by CMS.

CMS considers the RPC's a necessary element in the transition to Medicaid Managed Care.

STATE GOVERNMENT SUPPORT: The RPC is backed by NYS DOH, NYS OMH, NYS OASAS and NYS OCFS.

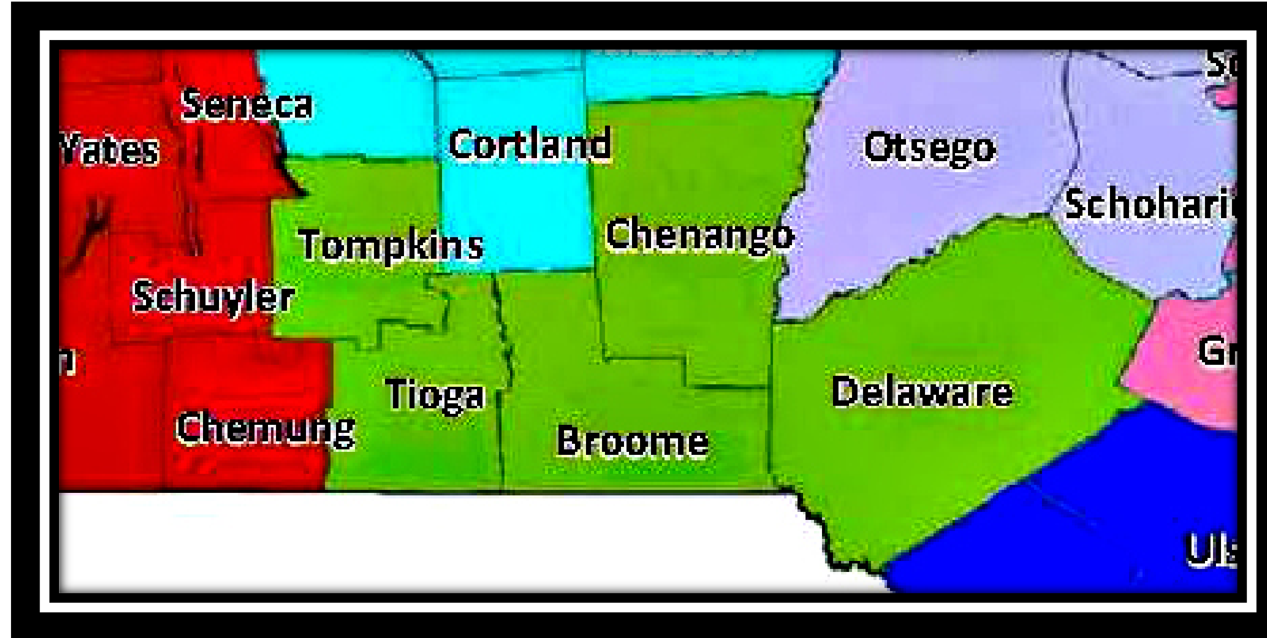
PLAN PARTICIPATION: The State has required each MCO/HARP to participate in the RPCs.

REGIONAL PLANNING CONSORTIUMS

WESTERN NEW YORK REGION	FINGER LAKES REGION	CENTRAL REGION	SOUTHERN TIER REGION	TUG HILL SEAWAY REGION	MOHAWK VALLEY REGION	CAPITAL REGION	NORTH COUNTRY REGION	MID-HUDSON REGION	NEW YORK CITY REGION	LONG ISLAND REGION
Allegany Cattaraugus Chautauqua Erie Genesee Niagara Orleans Wyoming	Chemung Livingston Monroe Ontario Schuyler Seneca Steuben Wayne Yates	Cayuga Cortland Madison Oneida Onondaga Oswego	Broome Chenango Delaware Tioga Tompkins	Jefferson Lewis St. Lawrence	Fulton Herkimer Montgomery Otsego Schoharie	Albany Columbia Greene Rensselaer Saratoga Schenectady	Clinton Essex Franklin Hamilton Warren Washington	Dutchess Orange Putnam Rockland Sullivan Ulster Westchester	Bronx Kings New York Queens Richmond	Nassau Suffolk

SOUTHERN TIER REGION RPC

Delaware, Chenango, Broome, Tioga & Tompkins



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REGIONAL PLANNING CONSORTIUMS

(PURPOSE, OBJECTIVES & FUNCTION)

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REGIONAL PLANNING CONSORTIUMS

PURPOSE & OBJECTIVES

The purpose of the RPC is to:

- ***"The RPC will work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend priorities for reinvestment of Medicaid savings."***
- **The RPC will work collaboratively to resolve issues related to access, network adequacy and quality of care occurring in the region around the behavioral health transformation agenda (specifically Medicaid Managed Care) and;**
- **The RPC will strengthen the regional voice when communicating concerns to the state partners and;**
- **The RPC will act as an information exchange and a place where people can come to get updates on the behavioral health transformation agenda.**

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RPC STRUCTURE & FUNCTION

STRUCTURE: In each region, the RPC will create a board comprised of:

- county mental health directors
- community-based providers,
- peers, youth & families,
- managed care organizations in the region
- hospital and health system providers (HH Leads, FQHC's)
- state field office staff
- key partners (PHIPs, PPS, LDSS and LHD)

FUNCTION: The RPC will formulate an issues agenda, use data to inform their discussions, collaborate together and resolve the issues identified within their region. The board will come together on a quarterly basis.

ACCESS: This meeting will be available to those who are not on the board via GoTo meeting beginning in 2017.

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RPC BOARD COMPOSITION`

- LGU / DCS (Up to 6 reps), 1 VOTE (20%)
- community-based organizations, (Up to 6 reps), 1 VOTE (20%)
- peers, youth & families (Up to 6 reps), 1 VOTE (20%)
- managed care organizations in the region (Up to 6 reps) 1 VOTE (20%)
- hospital and health system providers (Up to 6 reps) 1 VOTE (20%)

TOTAL - 5 VOTES (100%)

- state field office staff (Valued Partners in each region – Will advise the RPC around time-sensitive issues requiring input from NYS. (Ex-Officio, meaning non-voting)
- key partners (PHIPs, PPS, LDSS and LHD) (Up to 6 will be appointed) (non-voting)

EQUITY VOTE: Each stakeholder group's vote is equal to that of another stakeholder group. Issues requiring a vote will be determined by majority vote.

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REGIONAL PLANNING CONSORTIUMS

Elections & Board Requirements - Noel

RPC ELECTION MECHANICS

- THERE IS AN OPEN NOMINATION PROCESS. PEOPLE CAN NOMINATE THEIR OWN ORGANIZATION OR OTHER ORGANIZATIONS BETWEEN THIS MEETING AND THE LAST MEETING, OCTOBER 20TH.
- THE RPC BOARDS WILL BE BUILT USING A POPULAR VOTE PROCESS BY PEOPLE WHO ATTEND MEETINGS 1 OR 2. THE VOTE PROCESS IS STRUCTURED FOR CBOs, PEERS/FAMILY/YOUTH and HOSPITALS AND HEATLH SYSTEMS. KEY PARTNERS ARE APPOINTED TO THE BOARD.
- VOTING WILL OCCUR AFTER THIS MEETING, USING PAPER BALLOT or SURVEY MONKEY. Ballot will be sent out on December 19th.

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RPC ELECTION MECHANICS

- ONE VOTE, PER AGENCY/ORGANIZATION. ORGANIZATIONS MUST SUBMIT THE VOTER REGISTRATION FORM TO THE RPC COORDINATOR IN ORDER TO RECEIVE A BALLOT.
- ORGANIZATIONS WILL ONLY BE VOTING FOR THEIR STAKEHOLDER GROUP (I.E. CBOS VOTE FOR CBO BOARD, HOSPITALS & HEALTH SYSTEMS VOTE FOR HOPSITALS & HEALTH SYSTEMS)
- ONLY ONE PERSON FROM EACH AGENCY MAY SERVE ON THE RPC BOARD. *Exception in the H/HSP and P/F/Y stakeholder groups- This will be discussed further in the stakeholder breakout groups

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RPC BOARD MEMBER REQUIREMENTS

- BOARD MEMBERS WILL SERVE 2 YEAR TERMS
- ATTEND QUARTERLY MEETINGS (IN PERSON, NO PROXY) (Board Start Up could require monthly meetings Feb, March & April)
- BY VOLUNTEERING FOR BOARD CONSIDERATION, YOU AGREE TO REPRESENT THE COLLECTIVE VIEWS OF THE RESPECTIVE STAKEHOLDERS IN THE REGION
- BOARD MEMBERS SHOULD EXPECT TO SERVE AS AN ACCESS POINT FOR MEMBERS OF THE COMMUNITY WHO HAVE QUESTIONS OR WOULD LIKE TO BRING ISSUES TO THE ATTENTION OF THE RPC

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RPC VOTING PROCESS
TIMELINE

- DEADLINE FOR NOMINATIONS & VOTER FORMS IS December 16, 2016
- BALLOTS WILL BE DISTRIBUTED, AND VOTING WILL BEGIN ON December 19th (VOTING PROCESS LASTS 4 DAYS)
- RPC BOARD ANNOUNCEMENT WILL BE MADE January 9, 2017
- 1ST BOARD MEETING WILL TAKE PLACE IN February 9, 2017.

RPC BOARD MEETING (February 9, 2017)

AFTER THE BOARD IS SEATED, THE BOARD WILL:

- Select a co-chair
- Confer on appointments of key partners
- Receive information regarding the training from MCTAC
- Discuss the children & families committee (only standing committee)
- Discuss forming other subcommittees and/or AD HOC groups
  - (EX., JUSTICE SYSTEM, NETWORK ADEQUACY, DATA)

- Note: The children & families committee will be chaired by an RPC board member. It will be populated by child serving entities and peers/youth/families.

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ONGOING RPC PARTICIPATION

HOW TO HAVE YOUR VOICE HEARD

A seat on the Board is NOT the only way to participate in the RPC process. You can provide input and raise issues via 5 different ways:

- **Board Co-Chairs**
- **Your County Mental Health Director**
- **Your Stakeholder Group's Board representatives**
- **RPC Coordinator**
- **Membership on Subcommittees and Ad Hoc Work Groups - Each Region's Board will establish Subcommittees and Ad Hoc groups to address specific areas and needs relevant to that region.**

RPC CHAIRS MEETING

(STATEWIDE MEETING: PURPOSE, FUNCTION, RESPONSIBILITY)

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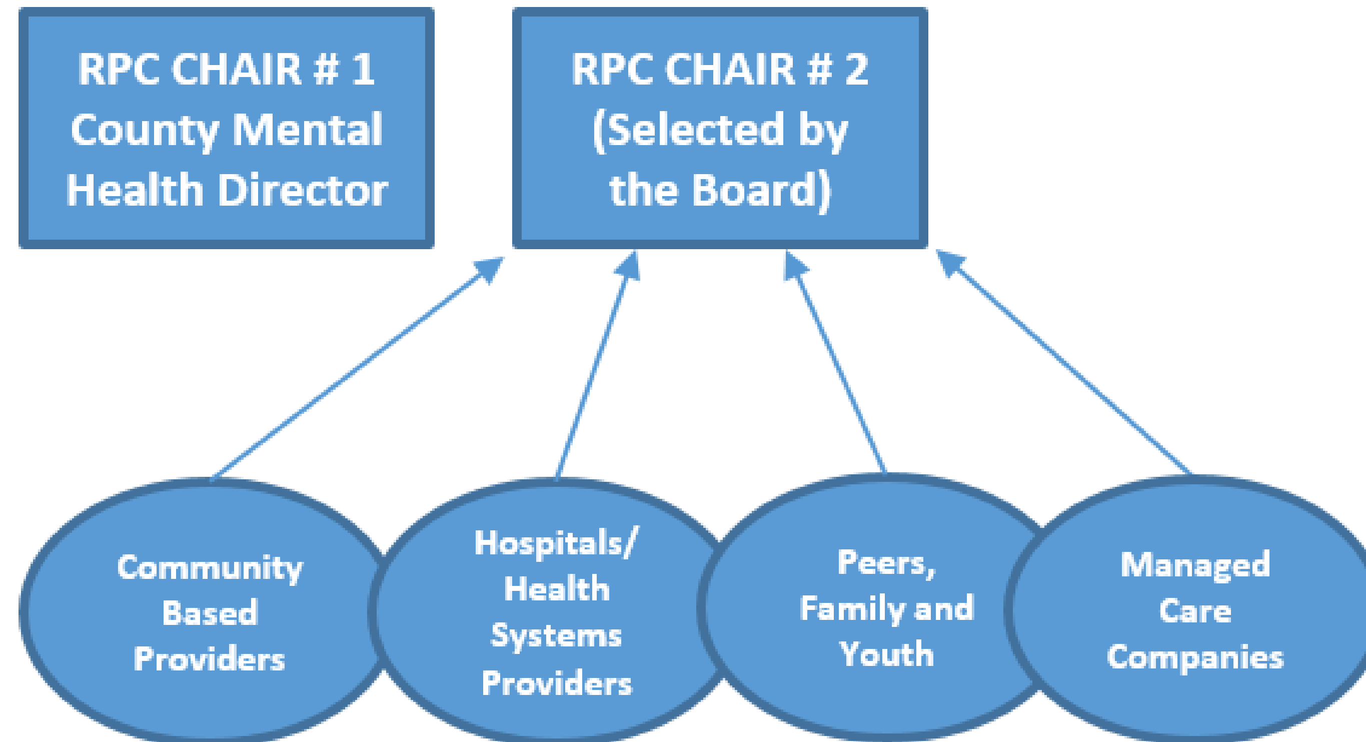
RPC CHAIRS

Each RPC will be co-chaired by a County Mental Health Director (DCS) and another individual selected by the board in their region, excluding the County Mental Health Directors group. The DCS is already seated, given their statutory responsibility.

ROLE: The Chairs will facilitate the RPC meetings. They will also represent their RPC at RPC CHAIRS MEETINGS.



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RPC CHAIRS MEETING

PURPOSE

The purpose of the RPC Chairs Meeting is to create a collaborative dialogue between the 11 NYS RPC's and with NYS government. This forum will be used to resolve issues that cannot be resolved on the regional level.

"The RPC will work closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend priorities for reinvestment of Medicaid savings."

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RPC CHAIRS MEETING

(FREQUENCY, ATTENDANCE & ACCESS)

FREQUENCY: The RPC Chairs Meeting will bring together the Co-Chairs from every region to dialogue with the state agencies on a quarterly basis. First meeting is scheduled for June 8, 2017.

ATTENDANCE: Leadership representatives from the Central Office(s) of NYS DOH, NYS OMH, NYS OASAS ad NYS OCFS will work together with the RPC Chairs to address and resolve issues occurring within the regions.

ACCESS: The Co-Chairs Meeting is an internal meeting.

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STAKEHOLDER MEET & GREET

(Meet & Greet – BREAK)

Please use this time to network, catch up with colleagues and build new relationships. We will reconvene for Next Steps in about 15 minutes.

REGIONAL PLANNING CONSORTIUM

(RPC SLATE DEVELOPMENT & Break out group Prep)

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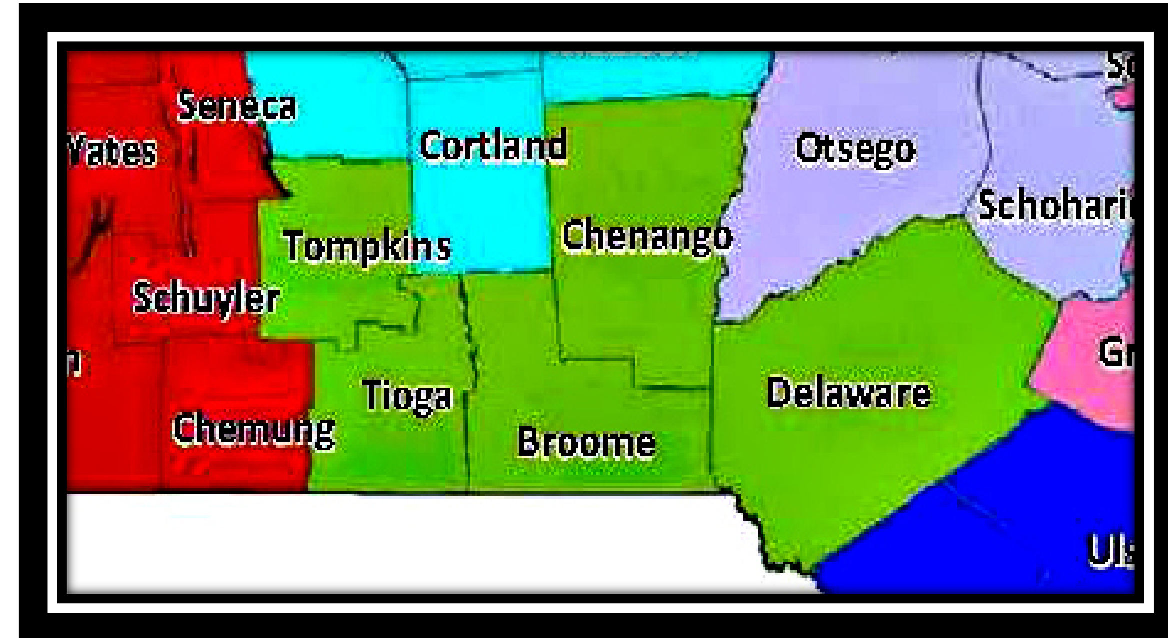
REGIONAL PLANNING CONSORTIUMS
UPDATES – COMMUNITY BASED PROVIDER SLATE

	CBO				
	Mental Health	Substance Abuse	Children's	Housing	HCBS
Broome	xx		xx		xx
Chenango	x			x	
Delaware				x	
Tompkins				x	
Tioga			x		
Total	3	0	2	2	2



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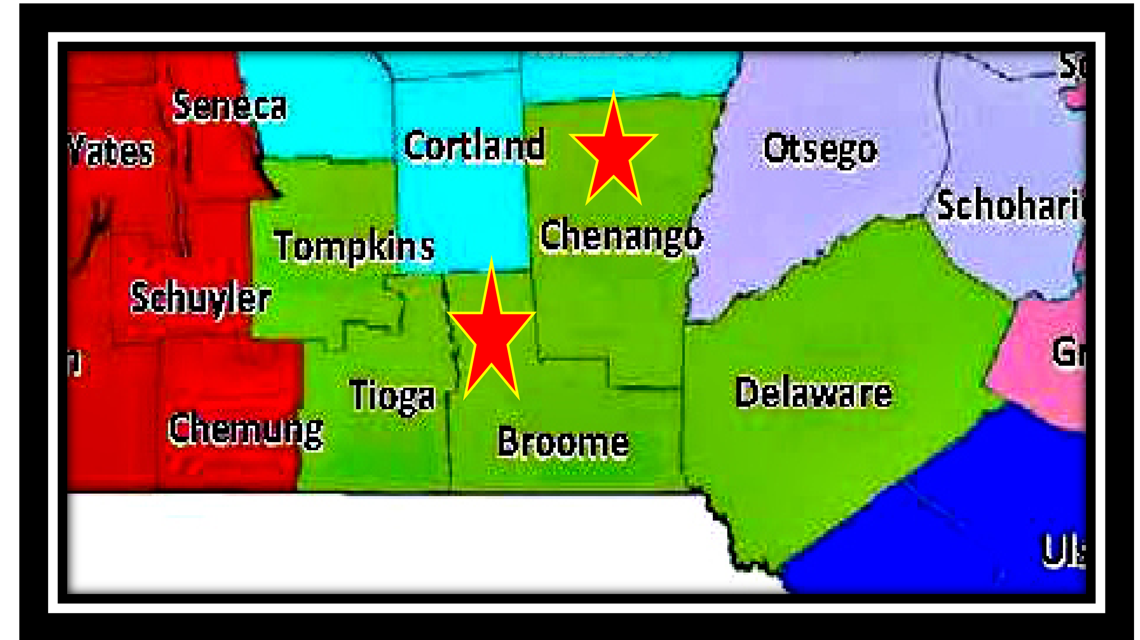
REGIONAL PLANNING CONSORTIUMS
UPDATES – HOSPITALS/HEALTH SYSTEMS SLATE

Hospital and Health System Providers				
	Hospital	PC/FQHC	HH	Health System
Broome				
Chenango				
Delaware	xx			
Tompkins		x	x	
Tioga			x	
Total	2	1	1	



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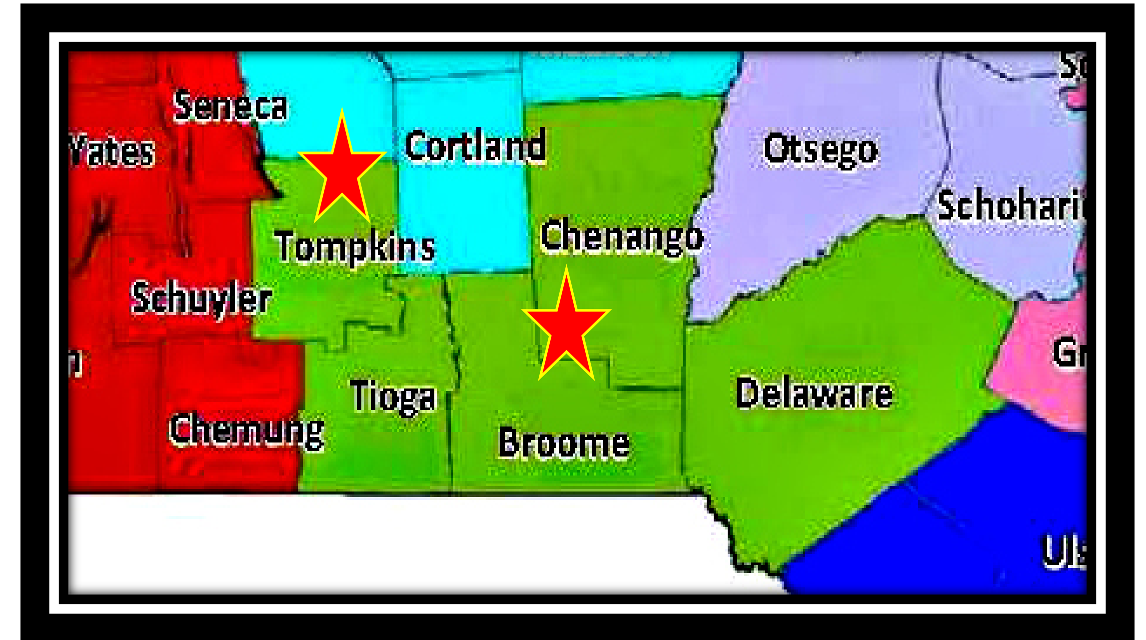
REGIONAL PLANNING CONSORTIUMS
UPDATES – PEERS/FAMILY/YOUTH ADVOCATE SLATE

Peer / Family / Youth			
	Peer	Family	Youth
Broome			
Chenango		x	
Delaware	xx	xx	x
Tompkins			
Tioga	x	x	
Total	3	3	1



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STAKEHOLDER BREAK OUT GROUPS

-INTRODUCTIONS

-FORMS

-EXPECTATIONS OF BOARD MEMBERS

-ELECTION PROCESS

CBO's – *upstairs, Lawrence Room – lead by Cindy Heaney, Ruth Roberts & Cathy Hoehn*

Peer / Family / Youth – upstairs, John Barren Room – Kim Saunders & Beth White

Key Partners – Auditorium, Front right corner – Sharon MacDougall & Katie Malonare

MCO's – Auditorium, Back Left Corner – James Button

Hospitals and Health Systems – Auditorium, Back Right Corner, Lori Morgan, Noel Feik

FOR MORE INFORMATION ABOUT THE Southern Tier

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Noel Feik
Mohawk Valley RPC Coordinator
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THIS SLIDE DECK CAN BE FOUND ON OUR WEBSITE (UNDER THE RPC TAB)
www.clmhd.org