INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th Street, NYC
January 25, 2017, 9:40-11:25am

M I N U T E S

Members Present: Christopher Joseph (Co-Chair) , Lisa Zullig (Co-chair), Lauren Benyola (by phone), Bláz Bush, Michael Ealy, Dorothy Farley (by phone), Deborah Greene, Graham Harriman, Zach Hennessey, Peter Laqueur (by phone), Jan Carl Park, Donald Powell (by phone), John Schoepp, Claire Simon, Brenda Starks-Ross

Members Absent: Christopher Cunningham, Joan Edwards, Terry Hamilton, Janet Goldberg, David Price, Bobby Rallakis

Other Council Members Present: Randall Bruce, Sharen Duke

Staff Present: David Klotz, Nasra Aidarus, Jose Colón-Berdecía, Kris Estem, Darryl Fields, Sahani Chandraratna, Bari Khan (NYC DOHMH); Bettina Carroll (Public Health Solutions)

Guests Present: Maryam Zoma (DOHMH), Alicia Korpi (Mt. Sinai), Michael Clarke (Housing Works)

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Mr. Joseph and *Ms. Zullig* opened the meeting followed by introductions and a moment of silence. The minutes from the December 22nd meeting were approved with no change.

Agenda Item #2: Medical Case Management/Care Coordination Service Directive: Other Payers (Health Homes and HARPs)

The Committee continued its discussion on a revised Care Coordination (CC) directive with presentations on Health and Recovery Plans (HARPs) and Medicaid Health Homes (HHs), with a focus on payer of last resort issues.

Ms. Zoma of the DOHMH Division of Mental Hygiene/Bureau of Systems Strengthening and Access, presented on HARPs, a new set of benefits offered by Medicaid Managed Care plans that are designed for people with higher behavioral health needs. HARPs cover all benefits provided by Medicaid Managed Care plans, including covered behavioral health benefits, but also provides additional specialty services to help people live better, go to school, work and be part of the community. Enrolment started in July 2015, and in January 2016, Behavioral Health Home and Community-Based Services (HCBS) became available for HARP enrollees.

HARP eligibility is adults enrolled in Medicaid and 21 years or older with Select Serious Mental Illness (SMI) and Substance Use Disorder (SUD) diagnoses having serious behavioral health issues. Individuals meeting the HARP eligibility criteria who are already enrolled in an HIV Special Needs Plan may remain enrolled in the current plan and receive the enhanced benefits of a HARP.

The State determines who is eligible based on who were high utilizers and should get more care coordination to prevent hospitalizations. HARP eligible people get a letter in the mail telling them they are eligible and how to enroll. HARP eligible people can choose to actively opt-in, opt-out, or be passively enrolled. The care manager, providers, and health insurance plans will work together to assist HARP members. Some HARP enrollees will be eligible for HCBS and be assigned a Care Manager, who will help HARP enrollees coordinate all their physical health, behavioral health and non-Medicaid support needs. HCBS are only available to HARPs enrollees and are not clinical.

HCBS service types include: Psychosocial Rehabilitation; Community Psychiatric Support and Treatment; Habilitation Services; Family Support and Training; Short-term Respite; Intensive Respite; Education Support Services; Pre-Vocational Services; Transitional Employment Services; Intensive Supported Employment Services; Ongoing Supported Employment Services; and Empowerment Services-Peer Supports.

HARP enrollees will meet with their Health Home Care Manager to decide what BH HCBS they may be eligible for and need. The HARP enrollee and Care Manager will work together to develop a Plan of Care. A Plan of Care focuses on an enrollee's life goals and the services needed to help reach those goals. Managed Care Plan reviews and approves BH HCBS and referrals are made to chosen BH HCBS providers. Care Manager continues to monitor Plan of Care and coordinate with all providers to keep HARP enrollee engaged and connected to services to meet their needs. As of January 5, 2017, there are 44,456 HARPs enrollees and as of November 16, 2016 of those enrollees, 13,690 are receiving HCBS.

The following is a summary of the discussion:

- HARPs are working on how to reach the hard to reach (e.g., homeless). There is no passive enrollment if the eligible person does not have an address.
- Clients must consent to allowing providers to communicate among each other and the process is more restrictive than HIPAA. HARPs go to great lengths to ensure client protections, especially around substance use treatment.
- Many of the HCBS service types are not reimbursable by Ryan White, such as crisis respite.
- A full HARP intake assessment is very intensive and can take up to 3 hours. The intake process for HCBS can be an additional hour.
- There are about 65,000 people eligible for HARPs in NYC. Those unenrolled could be because of unstable housing, or who opted out. Most of those enrolled were done so passively. Like SNPs, HARPs are on-going, high-level services.
- When someone is enrolled, nothing changes (e.g., same providers, etc.). It means that the person is now eligible for additional services.
- HARPs are not HIV-specific.
- It was unknown by the presenter if there are caps on services.

Ms. Korpi (Mt. Sinai) and *Mr. Clarke* (HousingWorks) then presented on Medicaid Health Homes (HHs) from the perspective of providers (Ms. Korpi from a medical provider, Mr. Clarke from a community provider). HHs grew out of the ACA and NYS Medicaid redesign as a way to replace targeted case management systems for people with conditions that are expensive to treat (e.g., mental health and HIV)

in order to identify and address the full range of behavioral, medical and social problems affecting chronically ill patients and improve health outcomes. HHs are a virtual network that includes the full range of providers (psychiatrists, social workers, case managers, home care, etc.) across multiple providers. Services also include family support and community services referrals. HHs enrollees must be Medicaid-eligible, so someone who is not (e.g., undocumented immigrants) would have to be referred to Ryan White Care Coordination (RW CC).

Mt. Sinai Health System (MS) is the lead provider and contracts with CBOs who make up a network of Health Homes providers. There are about 4500 enrolled in the HH, of whom about 1000 are HARP enrolled, but only about 10% of those are getting services (about average). MS does not yet have HCBS, and so as the main conduit for CBO providers who do provide HCBS, MS is working on new strategies to engage patients, such as getting alerts when HARP clients see a primary care provider and working with the managed care plans to get information on ED admissions. MS receives lists from the State of who is HH eligible and would not outreach to patients enrolled in RW CC to avoid duplication of services. MS can only see who is getting RW CC in the MS health system, not from an outside provider. If a client graduated from CC, then they can be enrolled in HH. With HARPs, MS is taking it to the next level, explaining to the client that they are eligible, and seeing if they want to enroll. Few have done so yet, but MS is working on looking at who might benefit. A barrier is that many non-HIV providers are not aware of RW CC.

HousingWorks (HW) has a referral practice that determines who is put in a HH and who in RW CC based on a number of factors. For HH: stable HIV disease with other psychosocial needs, Medicaid eligible. For RW CC: need for HIV treatment support, and retention in HIV Care (Medicaid or Non-Medicaid eligible). The higher level of support in RW CC is also preferred for people at risk for falling out of care. There are some slots for dual enrolment (no current waiting list). For the dually enrolled (done on a case-by-case basis), HH picks up entitlements/benefits, escort, and outreach; RW CC picks up assessment/re-assessment, clinical care coordination, treatment adherence, and health education/promotion. If someone is eligible for both but can be better served by RW CC, then they will be enrolled there, particularly if the greatest need is care management related specifically to the person's HIV disease. There is little good reason to opt out of HARP, as it gives you everything you already get in managed care, but also the option for additional services. As providers, we need to make people aware of the benefits of being in a HARP and explain the options. Providers can easily see who is HARP eligible through eMedNY. Also, SNP clients are automatically eligible for HCBS.

The following is a summary of the discussion:

- There might be people whose mental health issues might make it too difficult to understand enrolment and services offered.
- The lengthy intake process is a barrier to people getting services.
- There are no financial incentives or HH enrolment targets. For HCBS, providers are monitored on how many people have been offered the service, but not how many are enrolled (enrolment is done at the managed care level, not at the HH). There are higher payments for HARP-enrolled patients, as it is recognized that it takes more time and effort to work with seriously mentally ill patients.
- HHs do not include the treatment adherence and health education components of RW CC. There is a treatment adherence-only component of CC (e.g., weekly pill checks, DOT) so that dually-enrolled patients can get both services. Only a small number of people are dual-enrolled, and that is done on a case-by-case basis. Also, a HH sub-contractor may also provide food assistance or housing, which a HH cannot.

- The focus of HHs are to reduce ED visits and hospitalizations. The focus of RW CC is to improve retention in care and viral load suppression, so it is a different model, as only RW CC is HIV-specific.
- CC has a higher level, more intensive of service and lower caseloads (often a maximum of 20 patients, as opposed to up to 70 in HH).
- RW CC is also a field-based model, unlike HHs, which are mostly hospital-based, with no accompaniment.
- RW CC slots are limited and largely taken up by people who are not even eligible for HH or who have HIV treatment adherence needs.
- If HHs become more expansive and move towards passive enrolment, we might consider limiting RW CC to the non-Medicaid eligible, given the possibility of shrinking resources. A patient's own expressed needs should also be considered (i.e., do they have a priority need for HIV treatment adherence).
- Not all providers are trained to assess who needs HCBS. Social workers need to go through a rigorous training to do HCBS assessments and cannot do assessments without proper qualifications.
- There is no guidance for RW CC on how to make decisions about where to enroll clients, and that is something IOC should consider when developing the new service directive.

Staff will work on a CC/HH/HARP side-by-side comparison for the next meeting that encapsulates what was discussed today.

Mr. Park announced that all IOC members are invited to a Council and committee member strategic retreat to be held on February 16th, which will help us plan for possible changes to the health care delivery system under the new administration.

There being no further business, the meeting was adjourned.