HUMAN SERVICES COMMITTEE
Monday, May 14, 2018 - 9:30 PM

Charles Harrington, Chairperson
Noel Merrihew, Vice-Chairperson

Chairman Harrington called this Human Services Meeting to order at 9:30 am with the following Supervisors in attendance: Robin DeLoria Archie Depo, Shaun Gillilland, Joseph Giordano, Charles Harrington, Ronald Jackson, Mike Marnell, Stephen McNally, Noel Merrihew, James Monty, Ron Moore, Gerald Morrow, Roby Politi, Randy Preston, Tom Scozzafava, Michael Tyler, and Joe Pete Wilson. Dean Montroy had been previously excused.

Department Heads present: Judith Garrison, Krissy Leerkes, Dan Manning, Michael Mascarenas, and Terri Morse. Daniel Palmer and Linda Beers were absent.

Also present: Jim Dougan, Margaret Bartley, Barry Brogan – North Country Behavorial Health Care Network and Joan DeCesare

News Media present: Keith Lobdell - Sun News

HARRINGTON: We'll call the Human Services Committee to order and begin with the Pledge of Allegiance. The first order of business is the Department of Social Services, Mike Mascarenas.

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The first item on the agenda was the Department of Social Services with Michael Mascarenas reporting as follows:

MASCARENAS: Good morning, I do have a resolution this morning, a resolution authorizing the Traffic Safety Department to apply for and accept Governor Traffic Safety Grant in the amount of $22,000.00 for Local Highway Safety Grant, for $5,400.00 for Child Passenger Safety and $6,120.00 for Police Traffic Services and authorizing the execution of a contract with New York State Governor's Traffic Safety Committee. These grants are in and out, there's no local match required on those, we simply spend what we get.

HARRINGTON: And endorsement of this resolution by Roby Politi, a second, please.

RESOLUTION AUTHORIZING THE TRAFFIC SAFETY DEPARTMENT TO APPLY FOR AND ACCEPT A GOVERNOR TRAFFIC SAFETY GRANT IN THE AMOUNT OF $22,000.00, WHICH INCLUDES A LOCAL HIGHWAY SAFETY GRANT IN THE AMOUNT OF $5,400.00 FOR CHILD PASSENGER SAFETY AND POLICE TRAFFIC SERVICES IN THE AMOUNT OF $6,120.00 AND FURTHER AUTHORIZING THE EXECUTION OF A CONTRACT WITH NEW YORK STATE GOVERNOR'S TRAFFIC SAFETY COMMITTEE
Moved by Mr. Politi, seconded by Mr. Merrihew.

HARRINGTON: Questions or concerns in regards to this resolution?

MARNELL: Do these have anything to do with the speed warning signs?

MASCARENAS: Speed signs are not an eligible cost at this time. They have been in the past. They kind of fluctuate on an annual basis on what's eligible and what's not. The $22,000.00 is really spent

on administrative overhead. They allow us to claim a salary on that. We are able to get some bike helmets and to bike rodeos locally that kind of thing. The Child Passenger Safety is strictly for car seats only. We do car seat checks here at the County and we do them in communities. So, if someone comes in and needs a car seat or has a defective car seat we're able to replace that and make sure that the child leaves with an approved, installed correctly, child passenger safety seat. The other grant really focuses on driving behaviors and allows us to pay for overtime for our Sheriff's Department to do stings or patrols that focus on driving behaviors, like following too closely, texting while driving, seatbelt usage, those types of things.

HARRINGTON: Any other concerns in regards to this resolution?

MONTY: Mike, the car seat, is separate from the one the Sheriff does too?

MASCARENAS: This is in conjunction with the Sheriff's Department. We administer the program. We purchase the seats. The Sheriff's Department gets some of those seats. They typically go out and do the safety seat checks in your community, because the Sheriff's Department schedule I have a tech in DSS, it's Dan Sadowski and he operates the fitting station here at the County, because he's here Monday through Friday and does whatever. So, we kind of share that grant. It's the same one.

MONTY: Okay, thank you

HARRINGTON: Any other questions? There being none, all those in favor signify by saying aye, opposed, carried.

MASCARENAS: This month, I know each month I focus on a different program area in DSS and this month I wanted to focus on the finances somewhat. I know there has been confusion, traditionally on how its reimbursements work, what percentage we do get back on items and basically the way I did it was with actual revenues and actual appropriations. I took it over a three year period, what we actually spent, what we actually received back from the State. It's on page 5 of my report there, there's a chart and I tried to keep it as simple as possible. You can see at the top of that page, we have several different funding areas, which can be federal or state funded and those are listed out above and they total about, just about $4.1 million. Those are what are ceilings are. So, again all those funding areas are capped, once we exceed those caps you potentially start getting into the local share to be able to supply those services that we're charged with and mandated with. However, in the child services area, once we exceed our caps in those areas, your CPS, your Preventative, your Foster Care, your Adult Protective, we then start getting 62% from the state on every cost in addition to our cap. So, the reimbursement rate is very high, until you reach that cap you get 100%, so if you could perform every service under that you would get 100%. After that it turns into 62%. Understanding these figures that I put in front of you, do not have Medicaid in them. Whether Social Services existed or not the County has a $6.5 million dollar obligation to Medicaid on an annual basis. It's simply a wire transferred amount, it's really a County obligation, not a Social Services obligation, it just happens to be in our budget, because you have to put it somewhere. So, that $6.5 million that's now capped, Mr. Palmer refers to it a lot, when he talks about budget and what drives our levy, that's one of the major drives, but it's really not a Social Services expense.
So, for every other service that we provide over a 3 year period, you can see that our reimbursement rate in 2015, that's the bottom chart, those are the actuals, it's 87.8% in '16, 86.4%, and in '17, 75.9%. That can fluctuate on an annual basis. Here's why; the State settles with us on that 62% that I referred to. In 2016 we received 2 payments from the State, so the revenue that year was driven

higher a little bit than it was in ’17, but theatrically we’re getting anywhere from 75% to 87% back on the services we’re providing on an annual basis to the constituents of Essex County. So, hopefully that helps clarify things a little bit. It’s the most simplest sense, it’s obviously way more complicated than that when you’re getting into each individual funding stream. I am working on breaking them down by program area, so I can see which programs are driving costs, but I wanted to start with the basic overall and get something to the Board.

HARRINGTON: Questions or concerns?

TYLER: This is just a, it’s not a concern, but the 60% or 65%, do you think it will go down below that?

MASCARENAS: Really, I’m thinking not. We’re seeing that stay pretty much the same. I mean that’s why I like to look at trends over a period of time. One are that we did take a little bit of a hit on, Mr. Tyler in 2017 was foster care. We lost $167,000.00 in that Block Grant; which you see above in the totals. That was a little concerning, because our foster care really is at an all-time high. So, when I’m looking at trends across what’s going on and how the money’s following it, it doesn’t make a lot of sense that is absolutely a concern of mine, with the opiate epidemic that’s happening we’re seeing all-time highs in CPS, all-time highs in foster care, we’re seeing longer stays in foster care, because our treatment options are really not great here in the North Country, so yeah it is disconcerting in that one program area, but in terms of finances we are seeing a pretty stable reimbursements in terms of that.

TYLER: Thank you

HARRINGTON: Other concerns involving this?

MASCARENAS: If not that’s all I got.

HARRINGTON: Any other questions for Mike? Thanks Mike.

MASCARENAS: Thank you

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The next item on the agenda was the Mental Health Department with Terri Morse reporting as follows:

MORSE: Good morning everyone and welcome to May; which is the Mental Health Awareness Month. I don’t know if any of you remember that from last year. So, this is the time of the year that we get to honor those individuals who have encountered, I don’t even like to say the word struggled, but have encountered mental health issues and I’m sure that we all know at least one person in our lives that have dealt with some mental health issues and hopefully they have overcome them.
I want to piggyback on something that Mike Mascarenas shared with you about the opiate situation in Essex County that we’re all very, very interested in overcoming. So, Sue Ann Caron, his Deputy, myself and Linda Beers from Public Health are meeting on a monthly basis to talk about how we can, what we need to do in this County to address it. I think we need to approach it both/and, meaning we need to approach the outcomes, the symptoms associated with it. So, for example,

medical assisted treatment, getting more access to substance abuse services. I guess as a mental health provider I'm more interested in let's prevent it in the first place. So, the research that I have in place is that what really underlines addictions and opiate addictions, especially, is trauma. So, one of the things that I'm doing at our agency is getting my staff more trained than they already are in the subject of trauma. Tomorrow morning we're doing a trauma informed care workshop across our whole agency, because we need to know more about how we can prevent the problem in the first place. So, that's what we're doing currently and also for the Mental Health Awareness Month.
I just passed out to you a PowerPoint presentation and to piggyback on last month's presentation about the North Country Behavioral Health Care Collaborative. I sort of alerted you to the fact that I was going to bring someone today to go into more of the particulars about what that will mean for Essex County. So, Mr. Brogan, Barry Brogan is going to be coming up and talking about that handout, answering your questions as best he can and I'd like to introduce Barry Brogan from the North Country Behavioral Health Network and the North Country Behavioral Health Care Collaborative. Is that correct?

BROGAN: Yes, thank you Terri. Do I need I stand here or can I walk around?

GARRISON: You can take the mic out.

MANNING: That comes right out.

BROGAN: Alright, good morning this is my first time appearing before this County Legislature. I think I've been up at Franklin County before. Thank you for giving us an opportunity to come and talk about some really interesting opportunities that are going to becoming available to the Essex County Mental Health Clinic.
So, again my name's Barry Brogan, I'm the Executive Director of the North Country Behavioral Health Care Network. The Network was founded back in 1997, we are a network of 20 not-for-profit providers that have services in 7 counties across the North Country spanning from Ticonderoga to Watertown.
I am here as a contract contractor to Citizen's Advocates. Citizen Advocates Incorporated is a large provider of mental health, addictive services and developmental disability services, primary in Franklin County, but they have services in some other counties as well, but the reason why I mentioned Citizen Advocates is they are the lead agency for this state initiative which is currently underway to bring behavioral health providers from a fee for service environment to a value based payment environment and so today we're going to give you a very quick briefing on what that transition means. This is a top priority of the State. They have already moved in this direction with both hospital and primary care services and now behavioral health is being brought into that as well. So, if we can go to the first slide, which is assumption #1, so I think Terri gave me a briefing on the presentation that she gave the Board of Supervisors last month. So, we're going to quickly run through assumptions, because I know that you all absorbed every word that she said and you probably went home and did a lot of research on the internet about what value based payment is and the reimbursement structure for behavioral health services, but just in case of those you that didn't spend a lot of time on that, this is our first assumption of the knowledge that you folks have. Basic understanding of your current fee for service system, so this is the traditional, you go, the patient goes to the physician's office or goes to the mental health clinic, they receive a service at that clinic, they have, in this case we're only talking about Medicaid, they have a Medicaid coverage of some sort, they provide they're Medicaid information to the clinic. The clinic has a rate for that service, there's some sort of a billing code. They submit the billing code along with the documentation from that visit, its goes directly to the New York State Department of Health; which is

the Medicaid designation agency by the federal government and then the Department of Health cuts a check to the clinic. So, very simple, you sell a widget; you get paid for the widget that you sell. So, one of the difficulties with this system is it very much incentives volume over quality and in fact it disincentives quality. The more you go to the clinic, the more the patient shows up to the clinic, the more the clinic makes and so for years, particularly over on the primary care side and on the hospital side, the reimbursement system has been changing direction to reward quality over quantity. So, we don't want to just see that you, that the patient had a visit, but we want to begin to see what impact that visit had and was the care good enough that the individual didn't show back up a couple of days later because the initial care was inadequate. So, this is now happening on the behavior health side. We're going to be incentivizing us to emphasize quality and good cost and being able to measure outcomes. So, there's our first assumption.

Moving on to slide #3, our 2nd assumption. This is already underway now, most of the fee for services already transition to Medicaid Managed Care fee for service and under this scenario, the New York State Department of Health; which used to pay the bills directly, they've now hired a number of managed care organizations; what we call MCOs across the State to manage their Medicaid book of business. So, they'll set for any given population, they'll set a price with the Managed Care Organization and say we're going to pay you so much to take care of these folks and the Managed Care Organization then goes out and contracts with panels of providers and these again, initially have been on the primary, hospital side, but now on behavioral health as well. So, Terri's shop probably has a contract with Fidelis. They may have a contract with United Healthcare. They may have a contract with MVP and over the years there will be others to come into our market, but those are the big ones that are here now, so other than that, the fact that we are now sending our bills to a Managed Care Organization rather than directly to the Department of Health, things are pretty much the same, it's still a fee for service world. The rates are still being controlled by the State of New York, so the managed care company has to pay, but on the other hand they also have some control other the utilization and prior approvals, so and some care management services that they're involved in. so, they are tweaking around the edges of utilization to try and keep costs at a relatively controlled growth rate and frankly that's worked to an extent, but it clearly has not been in the cost curve anywhere near what the State of New York would like to see.

So, that moves us to the far more complicated assumption #3. Alright, so we do, I do, I want to come around in case I need to kind of point out anything to anybody. So, on this chart, looking at the graph on the left oval there, the blue lines are Essex County Mental Health Clinic, blue vertical. The red vertical is the managed care organization. So, what New York State is doing is they are incentivizing through this behavioral health care collaborative program; which 15 providers come together in 6 counties along the Eastern Adirondack slope and have been awarded $1.725 million over 2 years to move these 15 agencies into a value based payment environment. So, I think we need to define what that value based payment environment looks like and by the way the fee for service environment that we currently live in is going to go away. So, doing nothing is not an option, doing nothing is not an option. Okay, so on the first vertical column, sorry let's look at the benchmark, horizontal line. So, under value based payment, level 1 scenario, the managed care company is going to set a benchmark for the population that you are serving. So, in this case we're looking at 15 agencies, we have gotten 6,000 to 7,000 covered lives, these are people that are primarily getting their services through mental health or alcohol and substance abuse providers, so we've got about 6,000 to 7,000 of those folks. So, Fidelis for example sets the benchmark at, let's make it easy, $100.00, so for the year, they're going to pay, they're going to make available $100.00 per person, per month to take care of this population. Okay, so the first vertical line, the happy face there, comes in right at the benchmark, so again we're still actually billing for fee for service, but we've got some twist there. So, in this case Terri's shop bills for the services for the people that she provides, her proportion of that 6,000 to 7,000 people and they come in right at the benchmark, right at $100.00,

everybody's happy and the management company gets their payment from the State of New York, Terri gets 100% of her payment, everybody's in good shape.
Okay, next scenario, next line over. Next line over, it turns out at the end of the year that Essex County Mental Health is coming at $110.00 a month per person. Okay, they ran over. So, in this upside only scenario, Terri is still going to get her 100% of her rate for those services that she provided and the managed care organization is going to take the hit. Now, of course they have all sorts of shock lost provisions with New York State Department of Health, but the fact of the matter is they're going to take a hit.
Alright, then under the 3rd vertical line, let's say that a portion of people that Essex County Mental Health is taking care of that they actually come in at $90.00, $90.00 per person/per month. So, $10.00 a month they save per person, they save the State of New York and they save that Managed Care Organization, Fidelis. So, who gets that money? That $10.00? So, under this scenario and again this is all, we don't have the actually percentages now, but for the stake of this discussion. let's say Fidelis is going to keep $8.00 of that $10.00 and $2.00 is going to back to Essex County Mental Health to reinvest in their programs and increase access, increase marketing, etc., etc., so they're going to get a reward for coming in under costs.
Alright, so that's Level 1 and that's probably where we're going to be starting with regards to these 15 agencies that are coming together to contract under a value based payment. We'll start at Level 1, but the State clearly wants us to go to Level 2. So, let's quickly go over that. So, under Level 2 they first vertical column is exactly the same, everybody gets their money, everybody's happy, there's no overage and no underage. On the 2nd vertical column their, what you see is that if Essex County Mental Health comes in at $110.00 per person/per month than $8.00 of that hit is going to be absorbed by the clinic and just $2.00 would be absorbed by the managed care organization. So, a far riskier environment. If Terri comes in at $90.00 for her patients, here's the payout. She gets to keep, Essex County Mental Health gets to keep $8.00 of the savings and the managed care organization gets to keep the $2.00. So, Level 2 is where the managed care organizations and the State wants providers to get to. The issues here are that to be able to do this small agencies, small providers like Essex County, like all the other 14 agencies that are in this project. None of them are big enough to do this on their own. None of them have the scope of services and the geographical coverage here in the North Country to be able to do this alone, so we're coming together as a group. Again we received a nice chunk of money to do this over the next two years, to put the infrastructure in place that will allow us to effectively compete in a value based payment market and the infrastructure is data driven, data, data, data. We have to know what a unit of service costs for all of our providers, for every single service, for every code that we're going to contract for and we have to know that those services are high quality. They we have access, we have customer satisfaction, that we're providing the best practice of services that the services we're doing are effective. The people who and this goes under this whole thing that they're calling now, population health. We can't just look at people as they are a mental health patient. They are a person living in our community. What's going on with them with regards to their hospital care? What's going on with them with regard their primary care? Do they have a primary care physician? What other chronic diseases do they have? Do they have a place to live? Do they have food in their pantry? Do they have a way to get to work? Do they have work? Do they have an education? This is a whole new world and we know that these, what they call social determination, all those things that I just mentioned, those non-clinical things have a huge impact on the clinical things and if we don't pay attention to those. If we don't work with the departments like Social Services and address the housing and the our placement of kids of into foster care. If we don't address those issues as a whole health care community and partnering with the social determination of health providers we're not going to get to whether we need to go and more importantly, as far as money goes, but more importantly the people who we take care are going to going to continue to just spin their wheels and not get better

and not improve our population health.
So, this is a big vision of the State of New York. This has been underway for about 5 years now. Behavioral health is just kicking in and unlike all of the other health care reform initiatives that have happened in New York State up until now, they're now investing in behavioral health and previously, the previous investments were pretty much for physicians and hospitals, but this is our turn and this is our chance to step up to the plate and come together as a group of 15 agencies and put out a decent product that a managed care organizations and other payers would be interested in.
So, let me quickly do a couple of other slides and then I'll ask if there's any questions.
So, we have to do well with costs and we have to do well with quality and there will be a number of quality barometries that will developed that will need to be put into the electronic health records at the clinic and they will need to measure those barometries on those quality indicators. They'll need to report those out, they will be compared to the other 14 agencies that are in consortium and one of the things that we will do as we come together is we will support those agencies that are lagging behind in the quality or running over in their costs.
So, slide #6, just gives you a graphic of how contracting might work. This is early days. We are only in the conception stages of this project and so, but this is what we, these are some scenarios that will be looking at. So, the North Country IPA is a group that has come together of 15 agencies. We will either contract directly with the managed care organizations as a group or we might go through the Adirondack ACO; which is owned by hospitals and physicians. It's based out of CVPH over in Plattsburgh and so there's a couple of different options and we may and I'm almost done here and we may in 6,000 to 7,000, if that turns out not to be a viable number of coverage lives. If we can't spread the risk effectively over that number of covered lives we could be looking at potentially partnering with some other IPAs or we could look at over provider groups, over types of providers to work together. So, again, very early days and we're still working on developing this.
Okay, I'm done, questions?

GIORDANO: IPA is?

BROGAN: Oh, Independent Provider Association. That's a unique legal status, it allows organizations to come together and bargain collectively. So, that it gives some shield, from anti-trust laws.

GIORDANO: ACO?

BROGAN: ACO is an Accountable Care Organization and that is, it's like an IPA, but they actually we're born over in the Medicare world. They're now expanding to Medicaid and they have to apply to become a Medicaid ACO and that actually the Plattsburgh group is doing that.

POLITI: Barry, you're talking about quality, you're talking about cost, high quality doesn't seem to necessarily go with low cost. I mean how is your quality, I'm curious. I mean how are you measuring quality?

BROGAN: So, that's a great question and then how do you assign value?

POLITI: Yes

BROGAN: Yeah, so we're working on that, but the quality piece in the beginning is relatively straight forward. So, it will start out as process. So, quality includes things like when someone calls the clinic for an appointment, how long before they get seen? When they come out are we doing patient

satisfaction surveys? How are we ranking on those surveys? We can, so there's a lot of process stuff. Are we checking for other chronic diseases? Are we checking to see if the individual does a follow-up, if they get referred for SUV services at St. Joe's, do they show up for that assessment. So, there's some process things, now that doesn't answer the question, does the person actually get better, does the person check all the boxes. So, that's where you start, you start by checking the boxes. The next thing is you begin to then look down the road, are we keeping that person out of the emergency room? Are we keeping that person out of the in-patient facilities; which the ER and in-patient facilities are the most costly to the system? How are we doing with those, are we seeing that they are controlling diabetes? Are they beginning to reduce their obesity? So, those are true quality and again as I said, data, data, data. The only way to do this is to link our system down the road here with the other 15 providers, but more importantly with a managed care organization and with the ACO, so that they can give us feedback, because we only see the mental health side or the SUV side, but we need to be able to see the hospital said and the primary care side. So, the systems are linking together now, this is a little bit tricky with regards to patient confidentiality and consents, but the infrastructure is out there and we will be tracking individuals across all the places that hit the health care system and try to intervene where we see people falling through the cracks.

POLITI: So, who's in charge with the measurement?

BROGAN: Well, initially the managed care organization will give us some limited number of matrix, it will probably be somewhere between, I don't know somewhere around a dozen to start out with and they will say these are the things that we want you to track. Here's how well you need to do on those, if you do well, you're going to get the extra money, if you don't do well we're going to being knocking down.

POLITI: So, are you measuring yourself?

BROGAN: Well, you're reporting to them. So, your system has to be, all the systems have to be able to measure apples to apples and oranges and oranges and you, so that gets collected as you do a visit, you are working with your patient, you're putting data into your electronic health record and at the end of the month that data gets mixed, matched, sliced and diced and sent to the managed care organization where they then give out the score cards.

JACKSON: I don't want to make you think that I have the wrong attitude, but it appears to me that the insurance companies, Fidelis, MVP, United are the ones that are judging quality of the care. Quality of the care effects how much they're paying out; correct? Do I see a big stumbling block here? I'm sorry Essex County Mental Health, you're not getting paid much this month.

BROGAN: Well they have to base that…

JACKSON: There should be somebody else other than the insurance company making this judgment call that affects what Essex County's getting paid for the services.

BROGAN: It's data though, it's not arguable, but we have the data too. It's not like we're sending out data and they're mixing and matching and we don't get to do that. We know what our data is. Essex County Mental Health is going to say, wait a minute, we met these, you can't knock us on this measure, because we met that measure. We exceed that measure, actually we should get a bonus for that.

JACKSON: How is that in there? Are there bonuses in there for doing a good job?

BROGAN: Yeah, so this is the bonus, the blue. So, if you come in under cost and better quality, you're going to get a bonus.
So, you know that is kind of, one of the good things about this transition is that it is based on data and if we have the systems in place and that's one of the reasons to come together as a consortium of 15 providers, is because for any one agency to build that data to capacity is prohibitive, it's very, very expensive, but as a group together utilizing these funds that are available from New York State, we can build that infrastructure and we can negotiate, based on our quality with those payers for the best price. You don't believe me?

JACKSON: No, especially with insurance companies making the call. That makes me nervous.

GIORDANO: So, I if understand you're right, you're basically improving efficiencies independently of each organization and then tracking as a collecting unit and then having incentives built in to, if you meet benchmarks?

BROGAN: Correct and there will be two levels of view, we're going to have internal reviews, our own IPA will have the ability to collect and analyze this data and so we will be working with our 15 providers to try and make sure folks are meeting their cost and data and their quality metrics, because we need that, because we're going collectively as a group to negotiate our rates and our services. So, we want to make sure that all 15 partners are strong as possible.

MONTY: Actually I have two questions; the first one is how much is this cost the County to join the group and the second question is, piggybacking on Ron, unless things have changed, I worked in a field very similar trying to get people help with addiction, mental health issues and they were seen by several of these providers that you have listed here, that's in your group and they were denied services by these insurance companies, because they had, their expert, who is reviewing the intake and all the information from the professionals and yet they're told, well, you don't meet the criteria, sorry, boom. So, I am very skeptical along with Ron on this.

BROGAN: So, let me do your second question first. So, one of the beauties and or risks of this new environment, so have things changed? Yeah, things have changed dramatically and they're going to continue to change.

MONTY: I don't know if they're changed dramatically, because I still have people in the business and we're still fighting with some insurance companies, so dramatically I wouldn't say.

BROGAN: So, utilization review will go away, as far as the insurance company goes.

MONTY: All insurance companies or just the one that you chose to work with; Medicaid?

BROGAN: Well, we're talking about Medicaid.

MONTY: Yeah

BROGAN: My decision is only about Medicaid. So, as risk is pushed down to the provider community, it's going to be the providers at the local level who are going to have to do utilization review and so, and again our incentive under the previous régime, the managed care company has

an incentive to reduce utilization, because, remember, more volume, more cost. So, they're gate keepers, they want to keep people away from here. What we want to do under the new environment is get people into care that they need, because that drives down costs, because again we're not in the little silos anymore, because if I provide care and so the person goes to the emergency room, that's the hospital's problem, well not anymore. Under this new scenario, population health, that's everybody's problem and if we, if we're dropping the ball, because we are denying access to somebody that needs it and that person end up in the emergency room, that is going to come back to haunt us when we define what value is, because value is keeping people in the community in health. So, have things changed? Sir, I will argue with you that they are changing dramatically and this is the ground level of that change and an important time for Essex County Mental Health to be involved.
What will it cost to join? We don't know yet. We are in the process. This is, we got this award announcement January 10th, somewhere in there. We have an executive committee that is meeting every week. We are building the blueprint, the roadmap for this project. We have a steering committee of all 15 agencies and the executive committee kind of works with the consulting group, builds the roadmap and the blue print and comes back to the steering committee. The steering committee, all 15 agencies, they make the decisions about how these resources, this $1.725 million are going to be spent. It's not the big providers, it's the whole group, everybody has an equal vote on how these resources get built and to Essex County's credit and also Clinton County and St. Lawrence County, all three of those county providers are at the table, equal partners, helping call the shots on how this is going to get done, but we don't, when we transition from a development organization to an independent provider association; which will be sometime, maybe around this time next year, there will be a call for capital and each provider that wants a seat on the Board of Directors of the new corporation will have to pony up that call for capital, what that will be, I don't know.

JACKSON: I just don't see it being covered, I'm sorry, I don't trust insurance companies.

BROGAN: Either do we, that's why we kind of like that they're going to be pushing some of this control down to the local level.

MORSE: So, I have two questions about a…

BROGAN: Well, I think we're out of time.

MORSE: So, not that this is going to happen, but let's just say that Essex County Mental Health is, for at least two years is not performing at a level, that drags down the rest of the 14 providers. What happens to Essex County? That's not going to happen, but what would happen?

BROGAN: As we develop the IPA participation agreement, so this will be, you're going to be joining a new corporation that will have, likely will have 3 county providers and 6 not-for-profits that are sitting on the Board of Directors. There will be some other not-for-profits that collectively, very small agencies that don't want to take on risk and they'll also have some representation on the Board, but it is one member for each agency. So, in that IPA, participation agreement there are going to be requirements to get into the IPA and there's going to be requirements for staying in the IPA and if you don't meet those requirements with regards to certain costs and quality thresholds then you will no longer be eligible to remain a member, so you'll get kicked out, not you, but the imaginary agency.

MORSE: Yes

BROGAN: And then that's not to say that if that organization is able to get their act together and then prove that they're making cost and quality benchmarks that they couldn't apply to come back in. This is be a fluid, there will be organizations that come in and go out over the course of the history of the organization.

MORSE: My second question and maybe, so part of me is really excited about the story that's laid out people's lives will be better with this value based payments environment. What does the Board of Supervisors need to know about how they can support Essex County Mental Health, but all the community based organizations, like ACAP and DSS, all of it, how can this Board support this initiative for their constituents?

BROGAN: Good question, so initially with regards to the development of the IPA, we'll start there. We're going to start with a pre incorporation agreement which is going to lay out what we think the IPA is going to look like. So, that will require a, that will require some sort of a decision on the part of Essex County, however that happens to sign that agreement. That will be legally binding document and it will have some money attached to it, so you know, we're in, we've talked about being in for 6-7 months, but now is the time to put a little money on the table for those organizations that want to be at that first tier membership and be on the Board of Directors and I strongly recommend that Essex County consider that level.
With regards to support for the overall push for population health, you know again, it's early days and the IPA, as part of its mission and this Behavior Health Collaborative and its mission has identified, already 22 community based organizations from Ticonderoga to Ogdensburg that are key additional partners that really address those social determinations of health types of components to a person's care and they traditionally are not Medicaid billing, they traditionally don't have a lot of incentives to work very closely with behavior health providers. So, that is going to be a heavy lift for the IPA to get these folks engaged and to figure out how we're going to get them in here and then how we can reward them for coordinating their care with our services as well and I don't have those answers yet, but what I think, you know one of the things that I, you know that I think is going to be very important is that the County has to be nimble. Some of these decisions, we only have a two year timeframe, we've got 24 months left to do this project. Some of these decisions are going to happen relatively quickly and it would be very helpful if you folks somehow put a process in place so that important decisions that are time limited have an expedited way to get through the decision making process. Clearly, we have found that working with the 3 counties is one of your most challenging obstacles to moving this project forward on a timely basis and we understand that there's a difference from a public entity to a private non-for-profit, we get that, but this is going to be a very unique public/private partnership and so we're being accommodating, we need the counties to also be accommodating to the extent that they can under the rules and laws that you operate under.

MORSE: I think the Attorney has a question.

MANNING: I just had a couple of questions, just by the definition, valued based pricing kind of jives with what Roby and Mr. Jackson said. It seems like we're concentrating more on costs as opposed to care for the individual. If we enter into this organization do we lose the autonomyyou're your providers, our doctors lose the autonomy to make the decisions that they need for the care of their patients versus a list of criteria that you say they have to check off to be paid? Is the care going to suffer, because we want to improve efficiencies or save money?

BROGAN: Well remember at the end of the day we want to see that people are staying healthier; okay? So, there are metrics through best practices and a lot of research that will be put in place, that we will be measured against and if we do these metrics the research would say that we're going to be able to provide that care at an efficient cost and at a high level of quality. Now, do they lose autonomy, no. So, physician always under managed care have been able to go kind of off script, leave the reservation, provide a care plan that's non-traditional, as long as they can prove it works.

MANNING: So, let's say I'm a doctor and I determine that my patient needs a certain degree of care, but it's not on the list, I'm not going to get paid for that care, because it doesn't fall within your metrics, but it's important to me and I'm a doctor, I know more than your people with the metrics, what I need to do to this patient, will the doctor, will Essex County, it's a doctor that works for Essex County, will we be paid less, because they're not adhering to your metrics? You know their professional opinion should matter more than somebody who thinks well this is what you do to pigeonhole someone within the metrics.

BROGAN: It shouldn't, again the risk is moving down the providers. So, it actually should be more flexibility, so for example, your mental health medical practitioner might say you know this person really needs is, they need housing assistance, that's what they really need, they need a descent place to live. They're not to come to their appointments, because they're living out of their car or they're at a campground all summer. So, one of the things that we have, by being paid per member per month and having the bucket of money available at local level, if we have resources that are available, if we have some shared savings for example, because we're doing a get job, we could work with housing providers in trying to get that person set up with subsidized housing. So, that's work that isn't currently under the rubric of medical care or mental health care, necessarily, but that's the kind of flexibility that they, that the State absolutely wants to incentivize us to take on; which brings me back to the comment that I made just a moment ago; which is we have to engage as part of this process, we have to engage those social determiner of health providers, the educators, the people who do housing, the people who transportation, the people who do meals on wheels, the Office for the Aging, Public Health, Social Services, it's all together and they're pushing the responsibility down to us and giving us more flexibility to pull the system together rather than have it be siloed.

MANNING: And the current climate, our doctors, I guess Medicaid set a threshold for what they can paid for certain things. Our doctors order that and that's the way they're repaid?

BROGAN: Yes

MANNING: So, now we're adding this bunch of criteria to things that doctors have to adhere to in order to get paid? It's just not a threshold or a price per each level of care there are all these other?

BROGAN: And again there will be a transition. It will continue to be fee for service now, as we begin to build this infrastructure to work together. So, it will be a slow transition to where we are assuming more risk at the local level and do have more flexibility, but again they're looking for 80% - 90% of all New York State Medicaid dollars to be tied to a value based contract by 2020. That is really soon, by April 1st of 2020. So, less than 2 years from now and again I think at that point in the game we'll be in that level 1 diagraph where if we're efficient we're going to get just a little bit of the savings, but I think by 2025, if the train continues down this track we're going to transitioning over to level 2 which is going to give us far more flexibility to do care management at the local level.

MANNING: And so this, we will contract with a MCO?

BROGAN: That's one scenario or we could contract with another group of providers, so like that ADKs ACO.

MANNING: Another MCO, sort of?

BROGAN: No, because they're not an insurance company. They're bringing together hospitals, doctors and their missing piece is behavior health. So, they're looking, they're really interested in contracting with us, because they've got, you know they've got the doctor practices and they have most of the hospitals in this eastern side, but they don't have a well-coordinated behavioral health solution and they are very much interested in talking with us about what we can bring to the that table.

MANNING: And if we contract with a MCO, they set the criteria and the standards that we have to adhere to?

BROGAN: They set the minimum standards, the IPA will set higher standards.

MANNING: The BHCC is the IPA?

BROGAN: It will become the IPA.

MANNING: IPA means a different thing to me.

BROGAN: So, the BHCC is a non-incorporated development organization, non-incorporated, doesn't really exist. That's why the money has to flow through Citizen Advocates, because they're a real corporate entity. but we would hope that by this time next year that the independent providers association, which we don't know what it's going to be called, but I'm calling it the North Country IPA, that should be launched and up and running by this time next year.

MANNING: And this only value based pricing for the Board's education, I mean the State of New York has codified that right? It's already in legislation, I think that there is a section of the law that is determining that we've got to do it anyway.

BROGAN: Well, you know, okay so I don't know exactly where this stands, but they're under contract with the federal government to get to 80% to 90% VBP by April 1st of 2020.

MANNING: And so if we don't participate what's the downside if we don't participate and are there any possible upside if we don't participate? I mean if just do what we're doing.

BROGAN: So, doing nothing is always an option, doing nothing, just business as usual.

MORSE: And some counties did.

BROGAN: Some counties have and those counties will be privatizing there mental health services in 5 years, they'll go away, because if you're not in a value based payment contract of some sort, you're not going to get Medicaid business. Now, maybe those counties have a high level of private

pay and maybe they have big contracts with employer insurance companies, well they can survive if they don't need Medicaid. But, here in the North Country Medicaid is a very, very important way to access health care and I don't know, but I would guess that Essex County Mental Health clinic probably couldn't survive without Medicaid contract. So, Medicaid you have to be in a managed care contract. Can you go it alone and this county may think you can, you guys have the purse strings, you can invest millions of dollars of the infrastructure, in the data infrastructure and the data analytics that the Mental Health Clinic would need to survive. That's your choice, you can do that, I'm a taxpayer in this county and I wish you wouldn't.

MANNING: But, aren't we doing that now? Don't we contract with MCOs right now?

BROGAN: You do, but you don't do any of the data analytics that they build.

MANNING: So this would basically be, not what you're talking about the State or the Federal government is basically forcing this down our throats.

BROGAN: Correct, yes, and for good reason, because what we have now, fee for service, more quantity, more payment is absolutely the reverse incentive to quality.

MANNING: And I'm not trying to be, I am just trying to get this information out to the Board. I mean it seems like we're stuck if it, it's Obamacare, it's socialize medicine, it's going to be what's it cost versus your care, but that's where we're at, it's not your fault, but it's just kind of screwy to me.

BROGAN: You know, you can call it Obamacare, I would call this an extremely conservative strategy for moving healthcare decision and risk to the local level with local practitioners making those decisions and having their dollars on the hook for good decisions, good care and improved population health. I think that's very, very conservation and it moves these decisions away from the government and down to the local level.

MANNING: But, again won't the MCO control, I mean we'll give them input, but they don't want to contract with us, because they have their standards?

BROGAN: Well, remember if we're able to stay together as a group of 15 providers, we have even mental health and alcohol and substance abuse clinic on the eastern side in our basket, with the exception of the hospitals and that when your diagram when it says other providers, you know that maybe something that we have to do down the road, get the hospital mental health programs in with us. I don't know, we haven't gotten to that part yet, but if they, in order for them to have a contract with the State of New York to make their money, they have to have a panel of behavioral health providers and we've got the panel, we are it, if we stick together.

MANNING: So, the upside would be that because there is this collective group of providers, 15 or so that gives us clout when we negotiate with MCOs? Do we get better rates?

BROGAN: We'll certainly try for better rates, 15 providers in the grand scheme of managed care organizations is still a pretty small fish in a big pond, but again we are, we are the vast majority of providers in this neck of the woods and they have to under their State contract have behavioral health services in all of their geography. So, I mean the upside in the County is just stay in the mental health business and you continue to have a County based clinic, if that's a priority of this County that will happen. If you're not in a managed care contract, excuse me, a valued based

payment contract, the competitors with come in here and they will set up a clinic next to your clinic and they'll hire your people away and pay them a little more. Well, they might be able to pay them more, the County folks do okay, but there will be competition that will come into here. If you're in the IPA, you're a seat at the table and you get to kind of protect your current operation, as long as you're meeting the metrics.
Any other questions? Thank you, you're been very patient, Terri told me I only 10 minutes. Thank you very much. I think you all have my card, I'm very accessible, you pick up the phone and call, that's my North Country Management Services card; which is the contract that we have with Citizen Advocates, any questions, please feel free to pick up the phone and give me a call. Thank you

MORSE: Thank you very much.
And I also wanted to make that same offer to each and every one of you, that if you have any questions about what was presented to you today you can always reach out to me or Dan has been fully versed on this initiative, so if you have any questions for Dan, too, that concludes my report for today. Thank you so much for your time.

HARRINGTON: Thank you Terri

MORSE: Unless, does anybody have any questions?

HARRINGTON: Any other questions for Terry today?

MORSE: Thank you

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The next item on the agenda was the Health Department with Linda Beers absent and no report was given.

HARRINGTON: Public Health, Linda Beers has no report.

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The next item on the agenda was Office for the Aging with Krissy Leerkes reporting as follows:

LEERKES: Good morning everybody. So, you should have my report, but I do have a couple of points that I just want to address within the report. So, a friendly reminder that this Wednesday is our 3rd annual senior celebration at Champlain Valley Senior Community. It will be held from 10:00 to 2:00, we have a great group of presenters that will be on slate to present in regards to older adults and some related topics. There will be a soup and salad luncheon, that's free of charge, provided by the Champlain Valley Senior Committee and we also have a bunch of different human service agencies on board that will be there to table and provide literature of older adults. So, Terri had mentioned that May is Mental Health Awareness Month, but it is also Older Americans' Month for us. So, each year part of the Older Americans' Month, is each of the counties recognize two volunteers. We have many, many, many volunteers without our county, whether it's with hospice or RSVP, Mercy Care, the schools, so on and so forth, that they all really, truly should be recognized, but the State only allows us to recognize two. So, this year I briefly mentioned this last month, but this year

we're recognizing Stephen Thompson from Ticonderoga and also Joan De Cesare. They'll be recognized at the State level, but I just wanted to bring some information about these two wonderful folks to you guys today. Stephen couldn't be here today, he's actually on the road driving one of our clients to dialysis, but just a little bit about him. Obviously, he's a volunteer driver, in 2017 alone, he logged over 11,000 miles in his own personal vehicle transporting folks back and forth to medical appointments in New York and in Vermont. These volunteers are only reimbursed mileage, they're not reimbursed their time. So, if you can imagine 11,000 miles, how long he has actually volunteered his time, so it's remarkable what he's provided to our folks. Just alone this year, from January to April, he has already logged over 5,300 miles and without all our volunteer drivers, including Steven, so many of our older adults would not be able to get access to medical care. So, our volunteers do not provide transportation to individuals with Medicaid. We use the medical answering services, also known as, MAS for those individuals, so these are older adults, 60 and over, without any other form of transportation, they have no, they potentially have no family in the area, no other formal support, so they truly don't have any other access to transportation. Our other volunteer, Joan De Cesare, who is here with me today, Joan just waved to everybody, thank you, Joan. Joan is from Keene. Joan originally started out as a title 5 worker without a contract for ACAP. She started out as a Title 5 worker there and then came over to our office and just recently decided to leave that role and volunteer. So, she still comes into our office, maybe once or twice a week, does some clerical work with us or for us, but I think most importantly, Joan has her own caseload of clients. Her weekly, monthly basis contacts these individuals and just has a phone conservation with them. So, she provides them with telephone reassurance and it's quite comical, sometimes, to hear her in there, saying have you went to your podiatry appointment, did you tell your primary care physician, because we can tell all the time, sometimes our folks don't listen, but they do truly do listen to Joan, so she's definitely as asset to our office. She has taken all of our staff as basically adopted children and I think adopted many of our children, so she's just a true asset to our office, so we're truly glad to have Joan with us.

Also, within my report, you should have a letter was addressed from NYSOFA Acting Director, Greg Olsen and then the Commissioner of Health. So, in 2018, Governor Cuomo in his State of the State he announced the launch of a long-term care planning council to prepare of the emerging needs to older New Yorkers. This is not new to you, in the next couple years our over 60 population is going to grow drastically and to be to over 30% here in Essex County and that's across the State, so this is a way with them with the State to take a look at the whole state and how we can prepare for that. So, at the bottom of the letter there is a link to a survey, where I'm just asking that if you have a couple of minutes to take the time to fill out this survey, so that the North Country is represented.

Just one other quick note, we are in the very early planning stages of implementing some intergenerational opportunities for our older adults and some of our high school students. We are looking at doing some tech health days. Some of our older adults have access to technology, but they may not know the ins and the outs of how to get their iPhone working or how to transfer pictures to Facebook, or even how to email. Having access to technology is really going to increase their ability to communicate with their friends, with their family, learn about the Medicare world, so right now, like I said, we're in very general, every early planning stages with Willsboro Central School and potentially another school to roll that out with some of their high school groups, their key clubs, hopefully some of their National Honor Society groups, so that's something that we're really, really excited to work on here in the future.

And I do have one quick resolution and that is to appoint Donna Crowningshield from the Town of Lewis as a member of the Essex County Office for the Aging Advisory Council for a three year term from May 1, 2018 to April 30, 2021.

HARRINGTON: An endorsement of that resolution?

RESOLUTION APPOINTING DONNA CROWNINGSHIELD AS A MEMBER OF THE ESSEX COUNTY ADVISORY COUNCIL FOR A THREE YEAR TERM EFFECTIVE MAY 1, 2018 - APRIL 30, 2021
Moved by Mr. Monty, seconded by Mr. Merrihew.

HARRINGTON: Questions, concerns? All those in favor signify by saying aye? Opposed? Carried.

LEERKES: Okay, that's all I have, unless anybody has any questions?

HARRINGTON: Any questions for Krissy?

MONTY: I'd like to offer a resolution of appreciation and thanks to your two volunteers of the year.

RESOLUTION OF CONGRATULATIONS AND APPRECIATION TO ESSEX COUNTY OFFICE FOR THE AGING VOLUNTEER OF THE YEAR RECIPIENTS, STEPHEN THOMPSON AND JOAN DE CESARE
Moved by Mr. Monty, and unanimously seconded.

LEERKES: Thank you

HARRINGTON: Thank you, any other concerns? Thank you Krissy.

LEERKES: Thank you

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The next item on the agenda was the Transportation Department with no report.

HARRINGTON: For Transportation there's no report. Human services we are adjourned.

MONTY: I have a few resolutions of condolence that I would like to offer from Human Services. First a resolution of condolence to the family of Doris Merrihew.

HARRINGTON: A second to that?

RESOLUTION OF CONDOLENCE TO THE FAMILY OF DORIS MERRIHEW.
Moved by Mr. Monty, and unanimously seconded.

MONTY: I'd also like to offer a resolution of condolence to the family of the Patrick Garvey. Dina Garvey's father in law.

RESOLUTION OF CONDOLENCE TO THE FAMILY OF PATRICK GARVEY
Moved by Mr. Monty, and unanimously seconded.

MONTY: And also a resolution of condolence to the family of Iola Collinson. The family was an anchor family in the Town of Lewis for hundreds of years.

RESOLUTION OF CONDOLENCE TO THE FAMILY OF IOLA COLLINSON.

Moved by Mr. Monty, and unanimously seconded.

MONTY: Thank you

HARRINGTON: We are adjourned.

AS THERE WAS NO FURTHER BUSINESS TO COME BEFORE THIS HUMAN COMMITTEE IT WAS ADJOURNED AT 10:40 AM.

Respectfully submitted,

Judy Garrison
Clerk of the Board