Ensuring Continuity of Care and Financial Stability During the Transition from Fee-for-Service Medicaid to Medicaid Managed Care

PHCH — NYC PROVIDERS OF HEALTH CARE FOR THE HOMELESS

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PHCH Mission Statement:

The NYC Providers of Health Care for the Homeless is a member coalition made up of agencies that work collaboratively to ensure high quality, accessible, and comprehensive health care to homeless persons in New York City.

Our Members

PHCH

Damian Project Samaritan Health Services

HELP/PSI — *Building Hope and Empowering Change* — FORMERLY PROJECT SAMARITAN

The Children's Hospital at Montefiore

Care for the Homeless

Children's Health Fund — Health Care and Advocacy for America's Most Vulnerable Children

Lutheran Family Health Centers

THE FLOATING HOSPITAL

Mount Vernon Neighborhood Health Center

HARLEM UNITED

RYAN CENTER — William F. Ryan Community Health Network

PROJECT Renewal

HOUSING WORKS

communityhealth — Hudson River HealthCare

Covenant House — Opening Doors for Homeless Youth

ICL — IMPROVING LIVES BUILDING HOPE EMPOWERING PEOPLE — INSTITUTE FOR COMMUNITY LIVING
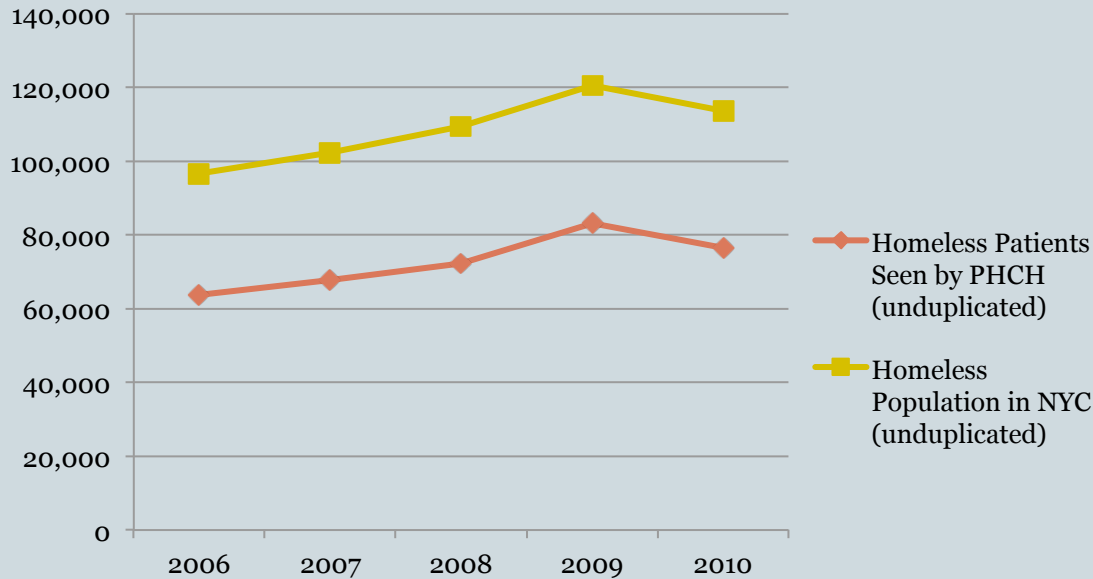
Unity Health System

Our Reach

Daily Sheltered Homeless Individuals in NYC as of 5/14/12: **41,313**

Total Homeless Individuals in NYC for 2011: **110,112**

Year	Homeless Patients Seen by PHCH (unduplicated)	Homeless Population in NYC (unduplicated)	Percent of Population
2006	63,607	96,612	65.8%
2007	67,650	102,187	66.2%
2008	72,245	109,314	66.1%
2009	83,101	120,381	69.0%
2010	76,493	113,553	67.4%

Our Reach

- 111 sites in all 5 NYC boroughs

- More than 15 mobile units, including specialty services vans for dental and mammography etc.

- Nearly 600 health related staff

- Total Homeless Individuals in NYC for 2011: **110,112**

- PHCH serves 1% of NYC's total population, or *1 in 100* people

NYC Providers of Health Care for the Homeless Sites

Sites
- Bowery Residents Committee
- Care for the Homeless
- Covenant House
- Damian Family Care
- HELP/PSI, Inc.
- Harlem United
- Housing Works
- Institute for Community Living
- Lutheran
- NY Children's Health Project
- Project Renewal
- Willian F. Ryan
- The Floating Hospital

Map Prepared by the NYS AHEC System
Data Resource Cencer 2012
www.ahec.buffalo.edu
RDC Sp12
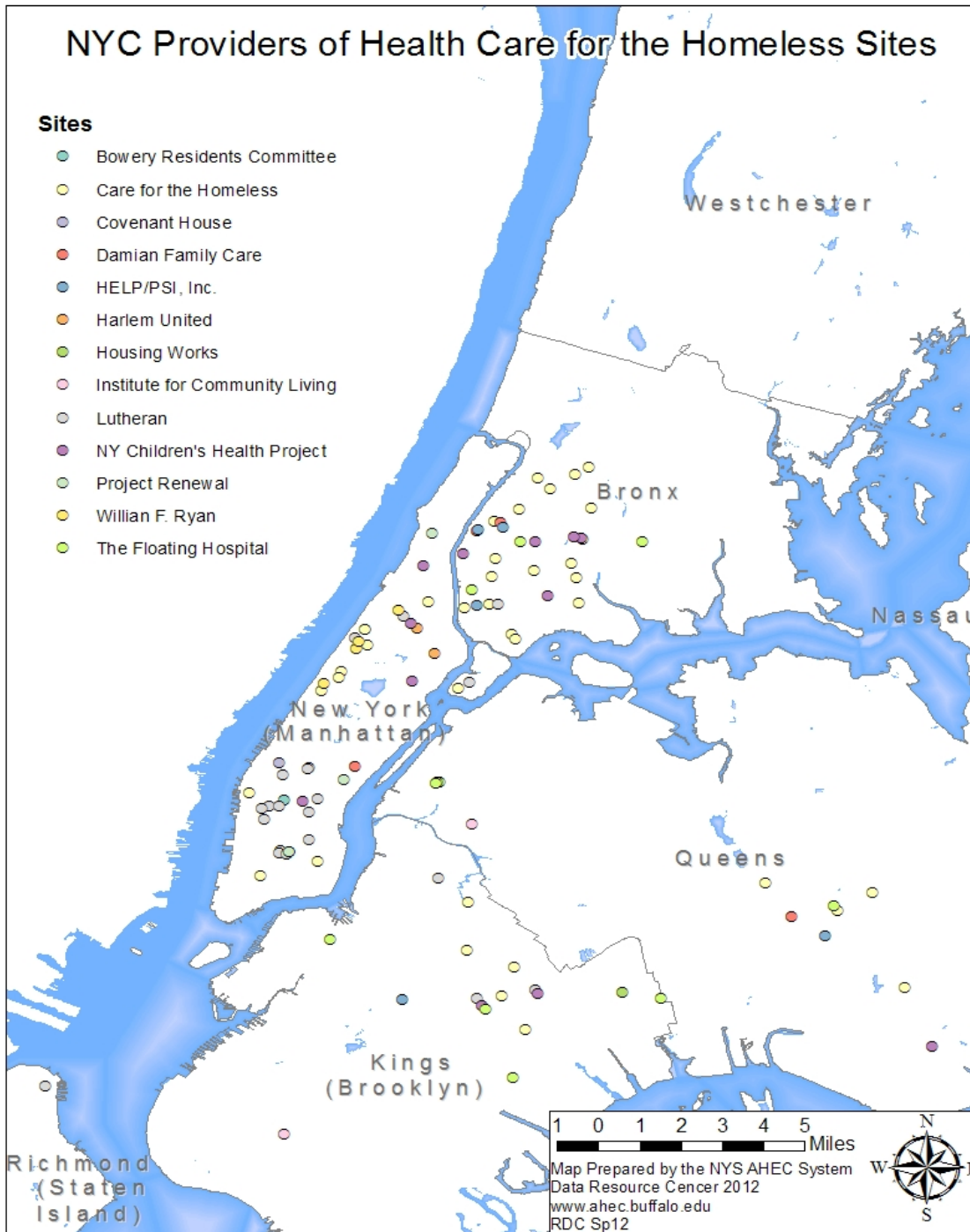
NYS History of Mandatory Medicaid Managed Care

- Partnership Plan, a Section 1115 waiver submitted to HCFA [CMS] in March 1995

- Enroll 2.7 million Medicaid beneficiaries, including the second largest homeless population (26,500/night and approx. 83,000/year, census) in the US

- First meeting of the NYC PHCH in December 1996

- Managed care demonstration project exempts homeless people and allows beneficiaries who become homeless to return to fee for service Medicaid

- Mandatory enrollment begins in NYC September 1999

- SERVING PEOPLE WITH COMPLEX MEDICAL AND PSYCHOSOCIAL NEEDS BUT WITHOUT PERMANENT RESIDENCES OR COMMON CHANNELS OF COMMUNICATION, IN A HIGHLY STRUCTURED, ADMINISTRATIVELY COMPLEX HEALTH DELIVERY SYSTEM

Guiding Principles

- Continuous access to convenient health care services when the individual believes care is necessary
- Availability of comprehensive services from providers experienced in working with homeless people
- Provision of care sensitive to the circumstances and needs of homeless people
- Minimization of systemic barriers needed to navigate managed care protocols
- Straightforward mechanisms and administrative processes for compensation to providers

Homeless Policy in NYC

- Any homeless individual enrolled in a managed care plan, who wishes to disenroll from their plan, may request an exemption. Homeless exemptions will be evaluated and, if approved, processed for a retroactive disenrollment effective the first of the month that the request was made...in most cases retroactive disenrollments are processed within three business days or less.

Medicaid Redesign Team (2011)

- "It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

  - Governor Andrew M. Cuomo, January 5, 2011

MRT Focus Areas

- Affordable Housing
- Basic Benefit Review
- Behavioral Health Reform
- Health Disparities
- Health Systems Redesign: Brooklyn
- Managed Long Term Care Implementation and Waiver Redesign

- Medical Malpractice Reform
- Payment Reform and Quality Measurement
- Program Streamlining and State/Local Responsibilities
- Workforce Flexibility and Change of Scope of Practice

Key Proposals

- Care Management for All

- "The State's overall goal is to expand enrollment in the Medicaid managed care program by requiring many of the high need populations which were previously exempted or excluded to enroll in a managed care plan. We believe that the Medicaid managed care program is a better model of care for these populations since managed care plans provide an organized system of care, an accountable entity, and the ability to coordinate and manage care."

  - NYS Department of Health

Populations Losing Exemption/Exclusion

- **Homeless (4/1/12)**   **15,325/4,000**

- Chronic Illness Demonstration(4/1/12)   554

- End Stage Renal Disease (4/1/12)   1,486

- Low Birth Weight Infants (4/1/12)   50-60 monthly

- Look-a-likes (4/1/12)   3,864

- Nursing Home Residents (10/1/12)   9,444

- Long Term Home Health Care Population (1/1/13)   2,690

- Parts of NYS Model Contracts did not fit the model of care an reimbursement utilized by HCH providers in NY.

- Quickly became evident changes would be necessary to maintain quality and access and to keep HCH providers financially viable.

- Series of stake holder work group meetings conducted to determine which of these changes practicable and necessary.

Categories of Proposed MC Strategies

- **Education and Enrollment**
  - Preventing auto-assignment
  - Preparing HCH providers and patients for new model of care

- **Access to and Delivery of Care**
  - Preserving continuity of care

- **Contracting**
  - Keeping providers financially whole and HCH system intact
  - Adapting MMC model contracts to HCH model

- **Other Issues**
  - Care Coordination
  - Transitional Resources to HCH providers

Education and Enrollment:
Identification and Eligibility

- <u>Identifying eligible population</u>:
  - Information should be collected at Medicaid eligibility determinations and through any other means if an individual is homeless or unstably housed. This information can be used to match individuals with HCH providers.

  - Cross checking the rosters with those of the NYC Department of Homeless Services (DHS) should be explored. DHS should provide the enrollment broker with an up-to-date listing of all DHS facility addresses. Issues of confidentiality and medical records should be considered.

  - Continually keep records of who is homeless; development of a homeless indicator in social service data and tracking ability—as homeless people move around

- <u>Presumptive Eligibility:</u>
  - The vast majority, close to 100%, of homeless people are income eligible for Medicaid in NYS. However, many do not sign up due to other constraints such as lack of navigational skills. Presumptive eligibility would enable people who find themselves homeless with automatic access to health care

  - Homeless people residing or receiving homeless services should be presumptively eligible for Medicaid. Often, they present to homeless clinics only at on-set of illness or when symptoms require immediate attention. Such services could be provided as fee for service until enrollment into a MCO becomes effective.

- <u>Mandatory MC Enrollment Notification</u>:
  - Contacting homeless people through mail or phone may be impossible, or delayed. Mail returned undeliverable to the eligibility workers or enrollment broker may exceed time frames for contrary actions.

  - Alternate forms of communications with people who are known to be homeless or unstably housed must be developed, including face to face notifications and time frames amended before auto-assignment or any other punitive action is taken.

Educating and Engaging Clients and Providers

- **Marketing Restrictions:**
  - Outreach activities by shelter based medical providers should not be confused with marketing prospective enrollees

- **Enrollment:**
  - HCH agencies should be able to facilitate client's enrollment into MC
  - Warm enrollment – when people working with a homeless person can call Maximus or the county and do a 3-way to educate and phone enroll
  - CBO & providers work together to help w/choice – identify plans that trusted providers contract with
  - Eligibility, enrollment, education workers should be stationed at family and adult intake centers and shelters
  - Establish a homeless culturally competent hot-line as well as educational programs and materials targeted to homeless people
  - Incentives for "trusted" providers/shelter staff to coordinate with community based facilitated enrollers

- **Stake Holder Trainings:**
  - Conduct trainings for all who play part in Homeless Health Care
    - Stakeholder training (Managed Care 101 – choosing a plan) All HRA staff on board, enrollers, plans, Community based facilitated enrollers, behavioral health organizations, shelters, clinics
    - AIDS Institute help train
    - Webinars others Web-based information disemination

Auto-assignment

- **<u>Auto-assignment of general population:</u>**
  - General population MMC members should not get assigned to an HCH provider's panel.

- **<u>Continuity of Care/Provider:</u>**
  - To promote continuity of care and ensure access, clients must be assigned to their present HCH provider. Must develop a mechanism to ensure clients are assigned to MCOs that HCH agencies have contracts with.

- **<u>Good Cause Disenrollment During Lock-in</u>:**
  - Individuals who are in locked-in to an MC plan should be allowed to change plans on an expedited basis if they become homeless and are placed in a facility where the clinic operator does not contract with their current MCO/plan (good cause).
  - HCH agencies seek the ability to bill from 1st of disenrollment (change of plan) month or have SDOH mandate payment by non-contracted plans when change of plan is delayed for this reason.

- **<u>Changing PCP</u>:**
  - Caps on the number of times or restrictions on the duration of time that must elapse before a homeless person can change PCPs should be lifted as homeless people receive multiple shelter/housing placements during the period of their homelessness. PCP changes must be expedited.

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- <u>Appointment Availability Standards</u>:
  - Standards for access to appointments and services may be too long for homeless people with long unmet and multiple needs and who often move from shelter to shelter.
  - The minimum standards set forth in the model managed care contract do not provide the flexibility and guarantees needed to get homeless people to important specialty appointments as needed.

- <u>Authorizations/Referrals</u>:
  - Pre-authorization for and caps on services which are federally mandated services under section 330(h) should be lifted as they will deny or delay care.
  - Other authorizations and referrals must be provided on an expedited basis.

Contracting
Credentialing and Reimbursement for Services

- **Credentialing Process:**
  - Expedited credentialing for HCH providers; short timeline requires quick process

- **The 16 PCP Clinic Hour Rule:**
  - Must eliminated or altered so as to allow for homeless providers to operate effectively and efficiently.

- Nurse Practitioners as PCPs
  - MPs provide significant care to the homeless population. Currently, not all plans contract and/or credential NPs.

- **Street Care:**
  - Care provided to homeless people living rough should be reimbursable on a fee for service basis until they enter and or access homeless services unless MCOs develop a mechanism for reimbursing street care.

- **Initial "Assessment" Visit Non-participating Provider Reimbursement:**
  - Some HCH providers will inevitably see member patients of MCOs they are not contracted with; good cause disenrollment not effective as timing for reimbursement does not work out.
  - Must be billed through fee for service or otherwise reimburses by MCO as non-par provider.

Contracting
Phase-in and Network Development

- <u>Network Adequacy</u>:
  - Enrollment should be phased in over sufficient time for homeless health care providers and MCO to contract, credential and build requisite billing and reporting expertise.

- <u>MCO and HCH Contracting</u>:
  - Contracts between NYS DOH and MCO(s) should specifically require MCO(s) to contract with all interested HCH agencies to mitigate their smaller market equity.
  - HCH agencies in NYS each fill an important niche and city cannot afford to lose any due to inability to contract with MC.

Other Issues

- **Care Coordination/Management:**
  - Confusion with Health Homes on enrollment and on-going care coordination
  - Must be emphasis on care coordination; allow HCH model of care to sustain

- **Transitional Resources:**
  - Technical assistance (financial or in-kind) should be made available to HCH providers to assure a seamless transition

End of Pre-implementation

- NYS SDOH issued "Guidance for Homeless Transition" on April 9, 2012
  - Many of our recommended strategies accepted
  - Panel discussion later will address the guidance and how transition is moving forward

Implementation

- A natural distance between Policy and Programming

- Much of the policy work in the implementation

- Moving from recommendations to realities
  - What was now an issue that had previously appeared to be resolved?

- Continual Temperature Checking
  - Contracting and Credentialing Process
  - Being sure to have the most up-to-date information

Panel Discussion

- **Roslynn Glicksman, MD, MPH–** Project Renewal
  - Medical Director for Primary Care
- **Sharon Joseph, MD, MPH –** New York Children's Health Project
  - Medical Director
- **Timothy Scutchfield –** Covenant House
  - Administrative Director
- **Barbara Conanan, RN, MS –** Lutheran Family Health Services
  - Program Director SRO/Homeless Program Department Of Community Medicine
- **Blanca Sckell, MD, MPH –** Lutheran Family Health Services
  - Medical Director
- **Tamisha McPherson, MPA –** Harlem United
  - Associate Vice President, Health Services