Utah Department of
Health & Human Services
Integrated Healthcare

Behavioral Health Delivery Workgroup
Meeting Minutes June 24, 2022

Participants

Committee Members

Adam Cohen, Jed Burton, Jennifer Ford, Scott Whittle, Joel Johnson, Julie Ewing, Kyle Snow, Russ Elbel, Tim Lougee attended for Brian Monsen, Nina Ferrell, and Lisa Heaton.

Committee Members Absent

Patrick Fleming, Senator Michael Kennedy, Jake Shoff, Tim Whalen, Representative James Dunnigan, Brandon Hendrickson, and Dr. Katherine Carlson.

DIH Staff

Jennifer Strohecker, Brent Kelsey, Brian Roach, Dave Wilde, Emma Chacon, Jennifer Meyer-Smart, Nate Checketts, Tonya Hales, Sharon Steigerwalt and Kimberlie Raymond.

Attendees

Debbie Williams, Jeniece Olsen, Todd Wood, Nelson Clayton, and Eliana White.

Welcome

Jennifer Strohecker: Okay, we are going to begin the recording and start our meeting today for the June 24th, Behavioral Health Delivery Working Group. We appreciate your attendance and contribution to the work that this working group is doing. So, thank you. We'd like to just acknowledge that we are recording this meeting and we'll be posting the recording on our website for your access and review if you'd like to do that as well as there are other meeting minutes and materials that are presented within the meeting. My name is Jennifer Strohecker. I serve as the director of the Division of Integrated Healthcare. I'm here with my colleagues to facilitate this discussion. We certainly appreciate your engagement and contributions to the work we're doing.

Review of Last Meeting Minutes

Jennifer Strohecker: We would like to move into the approval of our June 10th meeting minutes. You should have all received a copy of these minutes. If you have not, let us know. If you have a chance to look through these and if there are any changes please

bring them up. If not, I would love to take a motion to approve the minutes when you're ready.

Approve June 10 Meeting Minutes

Jed Burton made a motion to approve as presented, Russ Elbel seconded, motion passed to approve minutes.

Outstanding Concerns

Jennifer Strohecker: Now with regard to operational concerns, we set the stage last time with the commitment to work through operational concerns as they're identified and brought up. In this meeting, we want to make sure we have a forum for discussion and making sure we're working through any items that are an issue or a barrier to moving forward with our working group activities. So, in the context of our last meeting, what we committed to do first of all, was where there is an operational concern around claims, payment, billing, eligibility, or any of these issues that you are working on and they're one-off issues, we agreed to work on these offline. We invited you to first work with each other. If this is not done, we would love for you to work with the Medicaid teams. Specifically, Dave Wilde, in reaching out and letting us know that you have these issues. The sooner we know the better and we are committed to helping you reach resolution and us reach resolution with some of the issues that you're identifying. On the second piece of this is we said if there are more global issues, we certainly want to bring them to this setting and work them out here in a public forum so that we can work through the larger concerns. But in the context of these smaller concerns, we agreed to capture them and bring them back to this work group so that we could have visibility into them and show you what it is we've identified. We want to solve these, we want to work on them with you. Please join these discussions and don't let them go on and on so that we can actually help you reach resolution with some of these challenges that you're facing with claims billing claims adjudication. The document presented is embedded below in this document.

June 24 Presentation.pptx

Russ Elbel: The IOP bundle. Will you just explain the issue with that? And these were closed codes. Is that correct?

Dave Wilde: So currently for intensive outpatient and day treatment, we don't do a bundled code. We just have the plans bill individual codes. There was issues mainly when TPL is involved since they need to build a bundle code to a TPL and bill Medicaid. It's a lot simpler to bill a mental code. So, it would be bundling these services into a payment for IOP and for day treatment.

Adam Cohen: I wanted to make sure that the communication on the new rate is going well between State Medicaid, and the ACOs for this year. One of the plans said that they don't know what the rates are. So, I'm just wanting to get ahead of the issue because July 1st is just around the corner.

Jennifer Strohecker: I believe that in our meeting two weeks ago, I did have a slide with an email communication that did state an email was sent to both the ACO plans as well as the behavioral health providers with an update on the new rates, specifically what the rates were. And that they would be live in the system on July 1st. If there are any providers who have not received that communication, please let us know. The other issue, we've also identified is that the email has gone to a spam inbox. So, if we could just encourage providers to check their spam folders. Also, all of the PMHPs should have received this communication about our new rates for July. So that would be our residential treatment as well as the methadone increase. If there are any providers or individuals on this call who did not receive that but should have, please let us know

Tam Population

Jennifer Strohecker: I just wanted to frame our conversation as we move into the next piece of our conversation. We've tried to approach our first few meetings, with a very focused approach on our TAM member. The first column is looking at utilization data from our Medicaid utilization data. We were able to engage in greater discussion around other needs that come through utilization claim data that we know that this TAM population is receiving. It really is a necessary component of success in coordinating care and meeting the needs of this group. We know that outside of the public health emergency, this is a pretty small population. 5,000 Individuals are enrolled in TAM. In this TAM benefit, three fourths of the population comes from the justice system. The majority of these are male and are between the ages of 30 to 44. Most live in our five urban counties. And we see this from the density graph around where individuals are receiving care. Now, over the span of enrollment we know that we're looking not at frequency of care. But with regard to what care they are accessing about half of what our members have received. At least one visit to primary care and 39% had an ER visit. We looked at medicines and had a conversation around that. Here's a summary 31% of our membership received antidepressants, 21% antipsychotics and 18% of them have received MAT about half of our members have one chronic condition, according to our claims data. And one-third of them have both a co-occurring physical and behavioral health condition. 20% of our members drive 20 or 74 percent of the cost for this population. We have recognized that this does not tell our whole story. We know that sometimes access to care and engaging in care can be spotty. We know that we may not see exactly what the membership experiences with our utilization data. But we know that it's complex. It's high risk and high cost. And co-occurring conditions is something Brent's going to talk about a lot more today. We also know that this population also requires extensive coordination to achieve the health outcomes we're looking for and we have some of these captured. These are taken directly out of the

dialogue we had in last week's meeting minutes. We can add many more to these. But some of the things you brought up in our meeting last week talked about the requirement of intensive case management and care coordination. Care coordination can be achieved through community health workers or social workers, different points across the community, both government-funded and community-based services that we use to facilitate core care coordination in the community setting. And even to begin engagement in care as an individual, is leaving the systems and moving in, through risk assessments and working with jails. There were some great things brought up around one-stop medical visits and how because of the infrequent nature of members, engaging in care. And sometimes the difficulty of making sure we're able to provide comprehensive care. Also, community days where you run patient specific days that look at targeted event days. We looked at patient engagement and incentives, gift cards and food cards. There's all this medication and we're looking at medication adherence and the need for individuals. We know 21% of individuals are receiving antipsychotics, many of them injectable psychotics and the need to stay adherent to these. Strategies that have been put in place to achieve adherence and help members stay on their medicine. So, this is not an exhaustive list. With this, we want to really transition today into a deep dive discussion around what it means to define success in this population. I wanted to touch more specifically on a couple Medicaid specific items that were brought up in our last meeting and I want to make sure they're part of our conversation. The first is our 1115 waiver that has been submitted to CMS titled Medicaid Coverage for the Justice Involved Population. This was based on language that came out of House Bill 38 in the 2020 session. This was put into our 1115 waiver submitted to CMS in June of 2020. And what this looked at was getting Medicaid enrollment 30 days prior to an individual leaving the system and being able to have a smooth transition when leaving from the jail and moving into the community. To help have greater continuity and reduce interruptions in delivery of medical services and those services that are offered through the Medicaid benefit. We wanted to bring this up that this is still a priority to us. We are still talking to CMS about this and pressing them to work forward on this waiver. However, it has been put on hold by CMS because we're waiting on federal guidance. It's in a work group where they're trying to develop a more comprehensive package of what this can look like. And as a result, our conversations around this waiver have been halted at this time. We are still engaging with CMS and letting them know we want this. The other item, we wanted to bring up in the context of this population was eligibility. We know when an individual is enrolled in the TAM benefit and part of our TAM population are automatically enrolled in 12-month, continuous eligibility. This is a benefit because it's not month to month, we're not requiring paperwork, and that piece of eligibility is reviewed on a month-to-month basis. So automatically when an individual is enrolled, they get 12 months continuous. But there are a couple caveats that we wanted to bring to your attention that at the end of that 12-month time frame, if that member is still enrolled, they have another eligibility review with our DWS caseworker. If they are determined eligible for TAM at that time, then they stay on TAM for another 12 months, regardless of income changes. If at the end of the 12-month review period, they have income that actually puts them over the limit, they can become adult expansion eligible. If they are under the adult expansion limit, then they still may be eligible for the TAM benefit. There is this possibility that this

individual could transition to a different Medicaid program such as expansion which offers a different package or wrap around services than what we're seeing here and talking about with our TAM population. But it is possible, they could stay enrolled with the TAM benefit, as well, depending on income level and what that eligibility criteria is. Think about this as we move into on into our other work what integrated benefit would look like in the context of TAM is a fee for service population and our expansion population may have a different benefit service delivery system than the TAM population receives.

Tam Population - Next Steps

Brent Kelsey: House Bill for 413 asked us to form this group, to identify ways to improve the delivery of behavioral health services for our enrollees. And I think that we've provided data to you to demonstrate that the TAM population is not a population with just behavioral health concerns or just physical health concerns. This is a population that really has whole health needs and it has issues in both areas and requires coordination. Last month, we had a great conversation with you and to recap that a little bit, you brought up a number of issues that you felt were necessary to improve. We talked about care coordination and case management for community health workers. And the role that they play in helping TAM members navigate this system. We also identified that people need help with access and enrollment. People with physical health conditions, such as asthma and diabetes, often have higher rates of substance use disorders or mental illness and I think that we can see that in the TAM data. 50% of Medicaid enrollees nationally have some type of mental health diagnosis. Persons diagnosed with mental illness and common chronic health conditions their health care costs are much, much higher and the cost of diabetes treatment, for example, can be as much as four times higher. Individuals with mental illness often die 25 years earlier than the general population and substance use disorder also results in increased mortality. I think it's important to recognize the whole health needs of this population. We really want to focus on improving the health of the population within TAM and that really is the goal of this. We recognize that in doing so they'll probably be some cost savings too. But ultimately, I think that the goal that we've identified is improving the quality of care. Improving the health of the population that's receiving TAM benefits. What would that look like? What do you look at when you're evaluating your success with this population?

Adam Cohen: What we do as an organization to evaluate is look at reduction of symptoms like abstinence from drugs and alcohol or reduce use, no new incarceration, job, health care, complaints, wages earned, length of stay and how engaged they are.

Brent Kelsey: That's great. And that's very similar to the scorecards that we developed within the Division of Substance Abuse and Mental Health. Others from physical health, what are the metrics that you evaluate to determine whether or not we're making improvements?

Russ Elbel: Follow up after hospitalization. Are we able to get individuals engaged into follow-up care within 30 days or more, or ideally within seven days on discharge and measuring re-admissions? If you don't do the former with engagement, after hospitalization, you end up in a back in the hospital. Also looking at actual engagement rates in care management and looking at data on whose high risk and high cost and are we getting them into care management? And if we're not then what population is, which group are we not getting in and then how and then are we engaging them through other means such as outreach workers.

Brent Kelsey: Adam and Russ, when you look at that, do you look at engagement with behavioral health care? Is that what you're looking at specifically?

Russ Elbel: It's engagement. So, on the first two that I talked about readmissions and follow up after hospitalization, those are behavioral health specific but they're similar physical health measures particularly readmissions on the care management engagement. That's their overall chronic needs. So it typically includes you know everything it's behavioral health, it's social care, and it's physical health.

Brent Kelsey: My question for the behavioral health providers on the call, do you have any analysis or evaluation of a person's physical health needs? And what does that look like in your systems?

Jed Burton: We certainly evaluate that on intake for all of our clients. But we also, I think you're aware, have a primary care clinic embedded. That Weber Human identifies good outcomes on the physical health side in addition to behavioral health because initially we wanted to decrease cost to the physical health system. But that's hard to show over a short period of time. It's really easier to show over a lengthy period of time. So initially when we get people who hadn't been involved in physical health care primary care for several years, the costs went up quite significantly because we were getting them treatment for illnesses that hadn't been treated for years. So yes, we certainly do look at physical health issues and we're trying to come up with some short-term objectives or measures for those that we engage in physical health care. And I do like what Russ said, if they've been engaged with the community health worker or somebody that's on the physical health side.

Brent Kelsey: Great, Adam, I know you also have a physical health clinic. What are you looking at?

Adam Cohen: So, I'd say very similar to what Jed was talking about that we're looking at chronic diseases. Everybody who comes into any behavioral health programs, they tell their history and get a physical, so we can get a real good picture of their disease, what their physical health look like, and most often they have a number of chronic physical health conditions. So, our view of success is one either managing it through our primary care setting or connecting them to a specialist that can then get them stabilized and then

return to the prep to our primary care setting to continue chronic care management over time. And provide education about how to manage chronic diseases appropriately and preventative care appropriately.

Brent Kelsey: Now, that's great. I'm glad that the behavioral health providers are also thinking about the physical health of others. What are you looking at, Lisa?

Lisa Heaton: I think one area that we've struggled to codify that is really significant, are pregnant moms because it's not of course a disease, but so it's coded a little differently. But you look at moms that are able to struggle to find a way. How do you codify the outcome of having a child be born with fewer problems? Because those are really expensive births but they don't fall in the disease category, so I've seen a lot of issues that we could better. If we could find a way to codify it, we could get a lot better data on savings that way.

Brent Kelsey: Yeah, that's a metric that we've used in our system for a long, long time. We could probably use some assistance from the physical health side in terms of evaluating outcomes. Any thoughts Dr. Whittle or others?

Scott Whittle: I completely agree, and I think that that's a very important population to focus on. Getting that right would be fantastic. I'm just wondering how much deployment do you think we have in terms of putting physical health care into behavioral health? I've loved the projects and I think they're incredibly important. I wonder how much opportunity still exists there.

Brent Kelsey: Build on that a little bit Dr. Whittle. Last time you talked a little bit about this but why don't you expand.

Scott Whittle: I think it fits exactly what Lisa and Adam were talking about and Russ as well. If I were to take a guess, I would say we're probably about 10% deployed. In terms of meeting medical needs in behavioral health care settings, there's a lot of opportunity still there for doing good. Community health workers play that connection piece. And I think they'll be an important element of that strategy. To push the solutions, but if you look at that CCBHC model, a lot of the pieces of that are the coordinating elements that help connect these parts of our healthcare system together. I just wonder if we, as a group, agreed that there's a lot of opportunity for deployment and if we need additional support around those connecting elements to really make those to really deploy the way we would like to.

Brent Kelsey: Do people understand what Dr Whittles is talking about with the CCBHC model? What would be the recommendation Dr. Whittle about going forward with this group to explore that a little more.

Scott Whittle: Well I don't know if I'm the person to make recommendation but I'll tell you from my perspective, as a provider and as somebody who wants to support behavioral health care providers, what I love about the CCBHC model is that it creates a

strategy within Medicaid that provides for funding for providers who commit to a series of quality related services, that address the very issue we're talking about today. And, when you see a strategy that's both, fairly broadly adopted around the country is very reasonably priced and puts the funding right on the elements that were addressed today. You know, it seems like a strategy that comes with a couple of benefits to it. Well, adopted has a funding strategy associated and puts that funding right in the kinds of services that help us accomplish what we're looking to accomplish with blending that. But I tell you, it makes me a little nervous about these types of services together. Anxious with this very talented group to go too far out on a limb. I'd love to hear what other people are thinking about that framework.

Brent Kelsey: I think one of the exciting things that that we're going through as we come over to the Division of Integrated Healthcare is looking at our evaluation schemes. It may be reducing some of the burden on behavioral health providers and looking more at claims data and the measures. So that we can eliminate some of the burden that's been placed on clinicians. And I'm excited about those opportunities to align our data strategies and our evaluation strategies. I think that's an area where we can certainly improve. One of the things that we were tasked with doing is looking at metrics and establishing goals. Do people agree what we want to do going forward is focus on population health or a way of better serving this population? You know, it was interesting what Dr. Whittle said last time that TAM is a fee for service program, and one of the major reasons was we were concerned about access. I think it made sense to go with fee for service opportunities and then as we brought this group together, we talked to you about the needs of this population, and if you look at the meeting notes, pretty much everyone here said we need better care coordination, better case management, help navigating the system, and getting people to where they need to be. And you would kind of expect those kinds of problems in a fee-for-service arena. Right. So, we can solve those problems, but I think that's really where we are in the evolution of this is, how do we solve those problems. And there are some exciting things happening. How many of you are familiar with the collaborative care model? Our office will be releasing some grand opportunities for collaborative care, which is an evidence-based strategy for integrating physical and behavioral health services, and it can be implemented, within primary care or in other settings, and it includes care coordination and case management, regular proactive, monitoring and treatment and it's been studied in many different places all over the country. I think there's 70 different studies now that show positive outcomes from provider groups that are that are using this model. What other changes would you recommend to us, related to TAM? Is collaborative care the right way? Is CCBHC the right way? Let's have that discussion.

Dave Wilde: Brent, I'm wondering if people don't even know all the various models that are out there. We've been in a managed care state for a while and so I think if we could present the different options.

Brent Kelsey: I would agree, and I guess the question is, how do we want to proceed going forward? Do you want us to dive into one during our next meeting? Do we want to bring in some experts on CCBH and have that discussion as a group and explore it? Help me with some recommendations to keep this conversation moving in a positive direction.

Joel Johnson: I think it's a good idea to invite some experts in especially from some states that are a little further along on Medicaid reimbursement. So, here we are in the transition kind of bringing three different Medicaid's together, as TAM is enveloped by the ACOs, now, they're now dealing with one that has a 12-month eligibility, and then the experience that doesn't align networks is another issue, with people churning in and out of eligibility for Medicaid because of income. Maintain that continuum of care. And I think that's a topic I'd like to have for this group because it seems like it fits so well.

Adam Cohen: I think having some information on different payment models will be helpful. I think as we're talking about this discussion that we're not bringing a solution in search of a problem. Are we seeing real gaps in this population? Is this broken? So, making sure that we're not breaking something that isn't broken already. The second part is, I think if there is value in folding this into managed care and manage care in general, is to provide potential additional flexibility. I think what really needs to be discussed is that we need to treat this population not just behavioral health, not just physical health, but all the other social determinants that go into their long-term success. I think if we really want to have a robust discussion, we really need to start talking about it as a chronic care disease and starting to pay for it like that. So, like, episodes of care and long-term models of acute treatment but then the maintenance phase being all part of what we're going for at least on the behavioral health side. So, I want to make sure that we come out of this better than we went in, and I really do think we should be treating it as a chronic disease and in episodes, rather than days.

Brent Kelsey: Do you know of areas where we do this within health care areas? Or do you have recommendations you'd like to bring?

Adam Cohen: I think Scott would be really great to answer this but if you look at physical health and DRGs, if a woman is pregnant and gives birth, a hospital's paid a DRG for that and potentially if there's a complexity to it, they get enhanced payment, but that is pretty common on the physical health side. Like you are paid X dollar for this diagnosis and have varying levels of complexity that adds on to it. And I really think that works well. It is incentivized, both the provider and the payer have skin in the game and have positive outcomes and there's shared savings on both.

Scott Whittle: I think that's a fantastic idea. You know about the behavioral health side. There have been several national models. Moving towards that type of strategy with behavioral health. You take the DRG model, and you expand it a little bit to fit more the chronic model instead of episodic like surgical model. That's the most common application of DRG is procedure and then it just moves into the space where you're talking case rate and you put a time frame to it. You look at the clinical complexity in terms of medical social determinant and behavioral health and then you put a case right around that and hand it to a network of providers or a provider that's has a continuum of care that's robust enough to meet what would be anticipated in that course of care. And you provide a case rate for it and a great deal of administrative dollar and a great deal of flexibility, we've made big efforts to make that happen with an amount of success. I think there's a lot of people pointed that direction, both nationally and locally. I think it's a great idea.

Brent Kelsey: And does that generally happen within a managed care construct?

Scott Whittle: It's most comfortable in a managed care construct because it's something that managed care tends to be very familiar with. So, it leans into the value-based care contracting world that. We've all been encouraged to sort of try and flesh out so yeah, I think so.

Brent Kelsey: One of the things that that was interesting to me is that the problems that we identified during our last meeting about what this population needs, and gaps are the problems that I would expect to see within a fee-for-service system. With this population is that still the right payment structure or is that why we're having problems?

Dave Wilde: Brent on that, talking about giving TAM an integrated benefit. They currently have an integrated benefit through fee service, which also gives them the most access, the piece, as you as you noted is the care management piece. There are managed care models that just cover the case management piece that is the piece that the managed care plan would be providing. And then there's some value-based payments through that as the care management shows some benefit to cost and to outcomes for the members than they end up having some benefit to that plan as well. So, it's a win-win across the board so that way you still have a fee for service, you still have access but then you also have a robust care management program in place as well.

Scott Whittle: Yeah, I totally agree and let me just add one other concern out there because the fee for service model has coordination challenges. You're bringing it up, but it doesn't have the access problems, or it shouldn't. And yet we continue to have access problems across the board except for, in the areas where I think providers have really stood up and created a lot of access in the most critical areas. So, I think you have plenty of access. If you're at the higher acuity levels up into that high residential, because there was a lot of very thoughtful effort at making sure people weren't left without care at those levels. But if you go looking for care below the 3.0 level for individuals with these services, it

starts to get thinner. And when you get to the one point a level is where we really create the solutions we're looking for. And so, you know that you know this is one of my hopes is that when we start talking about the COC model, the collaboration of care model, which I think is absolutely essential. The CCBH model is I think very harmonious with the COC model, both of them flipped together very well. And so, I think those really are pointed at the solving that 1.0 level of care and trying to keep care at that level where appropriate so that it's that body. I apologize, I'm like a broken record with this but when you look at the body of the bell curve, it's the body that we're having our time with, not when people get into real trouble or when people are healthy, it's what do we do when people are medically ill and mild to moderately in trouble with something. On the social determine Behavioral Health Sud side, that 1.0 level just isn't the safety net, we need it to be. And I think those two models were talking about green and probably the best job that I've seen in terms of addressing that problem. So, I just wanted to make sure access is a problem. I don't see a short-term solution for unless some of these structural changes are made.

Brent Kelsey: In terms of next steps, as we look at metrics for this population, one of my recommendations is that we capture both physical health, and behavioral health concerns, and that providers from both arenas, essentially understand that we're trying to better coordinate care. You know, behavioral health providers understand that they have a responsibility to coordinate with physical health providers. Physical health care providers, understand the responsibility to coordinate with behavioral health and that we look at engagement and retention and making sure that the person's getting the care they need overall, and we look at that as success. Is anyone concerned about that direction?

Jennifer Strohecker: I think the one piece is, how do we capture that? What are those metrics? How do we capture that? And certainly, I think the bill does touch on some pieces. What are the other metrics? If we look at all the players in the room, payer and definitely the member, how do we capture our metrics of success around these three areas? We're thoughtful in these three areas? And I do think I want to make sure we're thoughtful in this because as we evaluate models that are out there and there are numerous ones, right? And certainly, we can come back to the next meeting and look at these various models and the benefits and things that could exist in them. We know this, we've taken our time to look at this and then we look at the needs and how we're capturing success through the model that we move towards, right? But what are those metrics and where do we have? What are the tools and resources? What are you using today to capture that? Is it claims data? Is it patient surveys? Is it a timely payment of all the payers' rights? What are those because they all matter in being successful?

Brent Kelsey: That's helpful. And what's interesting to me and what my next statement was going to be is that to me and I grew up in the substance use disorder side of the division. The most important metrics are about initiation, engagement, and retention,

and care for individuals with substance use disorder as we gather information. Those were the most telling things that we really had, it's not the best way. You know, we wish there was more but those were the elements that I think were the most highly correlated with positive outcome is and I think that most of the national quality metric development consultants would agree in substance use disorder which is very similar to what we were saying on the physical health care side. So, I think we could do a better job of gathering that within the Division of Integrated Healthcare, and I think it would be meaningful information in mental health. That's probably pretty consistent too, if you have someone that's diagnosed with major depression, initiation engagement and retention and care are probably pretty good starts. And that's data that we already have. Or could be developing through Medicaid for this population, but I don't think that we've emphasized it enough. In terms of these specific Medicaid programs and what that looks like, but what else?

Russ Elbel: I'll kind of build on what Jen was saying, so a couple things that people brought up that I think might be helpful going forward. One is Emma brought up the core set and it might be good for us to look at that. It's been a while since I've looked at the core set from Medicaid of measures that has been developed versus in HEDIS and they were working on alignment there. I don't think it was complete alignment, but it may be at this point. I think that would be worth looking at. I also think though that the piece Adam brought up about, moving towards a value-based system and I know this is a priority for the state as well. I think success looks like over time growth in value-based care and capturing that is important. And categorizing it to understand in which ways are we? How are we moving? Is it pay for performance type of value-based care? Aligning incentives to get the right outcomes? Is it moving towards bundled payments that allows what Adam described at that episodic care to be and all the incentives to be aligned for a provider to be able to deliver all the right care in under a bundle payment versus and all a cart fee for service type of choice and are the broader incentives being developed for a system to engage the system. I just think value-based care is probably a piece of success that Adam brought up his comments, and the example of DRGs in global deliveries on the physical health side. There's so much room for us to grow in this space that we should count that a success. But are we moving in the right direction?

Scott Whittle: Yeah, I couldn't agree more. I think that's really pointing in the right direction. It feels like we've dug into this a number of times over the last decade or so. And what we tend to find is the metrics that are handed to us by CMS and CMS associated organizations, can go from fairly general to in the weeds on some pretty detailed stuff. Because of our access problems, we've really had trouble dealing with the core issues in those measures. And so you end up looking at seven day access post hospitalization, post-emergency department admission, 30-day access to treatment post seven day 30 day posts. You're looking at things like readmission rates and although those things are

fantastic, they're still very general, but quite honestly, one of the core reasons I think we've struggled to make. And it is because of access. Because you can have a very well-intentioned system but if it doesn't have those pieces that reinforce with a broader base of human resource, connecting those elements, then it's really hard to make traction. And so, I think these comments really get to that issue. Because if we do create a value-based care arrangement, then the low dollar solutions for creating those connected pieces which are frankly, not licensed individuals which are one of our major challenges is the human resource shortage, were pieces are just not in that area. So that's right where that lives.

Adam Cohen: I just wanted to address some of the metric stuff because I think the discussion we're having is the method to get there. But I think we need to remember what matters to our patients and really to the legislature and the taxpayers. Are they out of jail, or out of prison, or are they out of the criminal justice system, or are they stably housed? Do they have a job or are they taxpayers? Are their symptoms reduced? Are they happier? Have we reunited a child with their mother? You know, like those are the things that matter.

Brent Kelsey: I'm hoping that as we align, those are the things that Medicaid can learn from us. Hopefully, we can learn to collect that information in a way that's less onerous. But, because I think those measures of productivity or recovery or engagement, you know, just a life in the community I think are really important because I think that's the ultimate outcome that can be retained in care and allows these systems to not be getting any better. And so I do agree with you. I'm hoping that we can sort that out and then build an evaluation strategy that brings the best of both of those worlds together. So, that's helpful.

Joel Johnson: I think I just wanted to touch on that, what you mentioned Brent and I think we talked about this before, maybe a year ago or so. But when it comes to metrics and ensuring providers, or tracking them, tying that tracking to metrics to the reimbursement mechanism may yield better results. So, if you may get part of the reimbursement structure that you have to track x, y and z, you know, and even the CCBHC front, then maybe you're one of those more highly aligned providers. Reimbursements, get better. But until providers are almost required to collect that data, they'll be collecting their own. Which shows, a 90% success rate.

Brent Kelsey: As I was looking to prepare for this meeting, I was looking at the collaborative care model for another assignment and I came across this statement and I wanted to throw it out there and get your response. We've talked a little bit about this and I think payment strategy is important but basically what Sam said identified that traditional fee-for-service reimbursement. Programs have been a barrier to widespread implementation of collaborative care. I think that that's one of the problems we have to solve for, and I think it can be solved many different ways. I think the discussion we've had

is pretty helpful and at least this group is in agreement that we need to be evaluating the health of the person and all of their needs, not just the needs that we've been assigned to serve. So that's helpful. I think we're having some of this discussion, but they also talk about capitation case rate payments, Adam. I think that's what really you're talking about or pay for performance mechanisms being sort of the solution to that. So, we're kind of headed in the same direction, right? Is that what I hear people saying? So, how do we get there?

Joel Johnson: Would it help to have an expert in these pay for performance scenarios, maybe the next meeting? Take 10 or 15 minutes, then answer questions. In a system from another state that's working, kind of the way that we're working to.

Brent Kelsey: It could be, what I'd love to do is talk with Jen and Nate and think about our next steps. If we're really interested in integrated care, we either have to solve the problems that the current structure creates, or we need to think about some different ways of doing this. Is that a fair statement? I think the problem that we're seeing is that if an individual walks through the Behavioral Health Door, we're concerned that their physical health needs are probably still being underdiagnosed. And in many settings, not at all and vice versa. If someone comes through the physical health door, there's sometimes a difficulty connecting to behavioral health and so making sure that we solve for that problem and we know there's a lot of work being done here. My favorite group is the Center for Excellence from the National Council. I think that they've provided excellent training and guidance to us in years past. And so that's another one that I would throw as a great source for information about how to do this. Administratively. Clinically. I think that they've provided some excellent resources.

Lisa Heaton: I know one thing that would help me and a lot of other people on here as well, if there are things that we could that you would recommend that we look at away from here, so that everybody's up to speed and we don't have to spend too much meeting time explaining some of these basic principles. I think that would be a training opportunity, and almost anybody here would be willing to do outside of here. Get us all up to speed on some of the things you mentioned.

Brent Kelsey: I think that's great and I just put a link in the chat to a brief on the collaborative care model that I found this week that I thought was excellent. And it goes through that and I'm not pushing or endorsing that model necessarily. But I was just trying to prepare for these conversations. I like where we got today and I think that in terms of how we would define success we would look at metrics from both physical health, and behavioral health. We talked about initiation engagement and retention really in both systems being important. We also talked about the need to look at additional metrics related to recovery productivity in the community. And trying to put those together. And then we started to talk about some payment models or some changes in strategy, that may

work to deliver more integrated care or to increase the amount of care coordination to identify or solve for the problems that we identified last week. And then there was a request made for this group for additional information about some of these models, and maybe having some expertise brought in to discuss this. Some of the things related, maybe to CCBH, maybe to integrated care or collaborative care. So is that a fair summary of where we got today?

Jennifer Strohecker: Thank you, Brent and everyone else for the robust discussion today. I want to be thoughtful about that piece around measurement and what we look at with regard to success measures quality that type of thing. I don't want to jump too quickly through that piece because it's complicated and some of the models and the payment pathways that were introduced today may be beyond the scope of what is possible in the time frame we have, right? Because these are largely different things than what we have in place today. I also want to put in perspective that Medicaid and CMS, and those things too are in the context and certainly central to the where we want to be in another year, right with July date in front of us. So, with that I would love to kind of capture our notes and put them in a summary so that we could just look at them collectively, even our second piece around. Sort of these wraparound services and these other additional services. I feel like we need more contribution in that area, it's out there, I don't want to miss it. This is an essential piece to success for this group yet. It wasn't on this, brief list that I showed today and so I do want to spend a little bit of time engaging in that and also bringing back these other pieces that were discussed today. Around how we look at value and how we look at success measures and I love that we talk about HEDIS measures and things. But it really does come back to what matters to the patient to, and what matters to them in their life and what is success to them. So, we want to engage in those pieces too and not just jump through those to get to our the end. I'd like to spend a bit of time at our next meeting mulling that over. And so, if you could do that and bring back your thoughts as well for discussion or just adding to that, I'd like to do that and maybe not rush too quickly through those pieces.

Joel Johnson: I sent an email out a couple hours ago outlining a couple things from the provider perspective, trying to take into account all the changes, the merge, any one of those is just a guideline or an idea. So, feel free to throw those into the agenda how you'd like, but those are things that can kind of consistently come up on the provider side.

Q&A

Brent Kelsey: Well, we've got we've got about 10 minutes left. That's our traditional, Q&A time. I appreciate this group's willingness to participate. We're really going to rely on you to help us move this someplace positive. We certainly don't want to make the system worse and I take Adam's challenge. Seriously, I know that sometimes we put this group

together and we end up going backwards, so we want to avoid that at all costs. Do you have suggestions or recommendations to us about next steps to keep us on track and in line with the work that we're supposed to be doing?

Joel Johnson: Brent has a 30% increase with those two residential codes being codified in rule. Have come up with the rates? You know what I'm referring to.

Jennifer Strohecker: They'll go live on July 1st. So those will be implemented July 1st. They did not go through the rulemaking process. We generally don't put our rate increases or rate changes through rule, but they are in our policy and have been distributed to behavioral health providers, PMHPs, and ACOs. I'm sorry, not BH providers but they were shared in the very early parts of this chat. If you can see those, those were noted there, and they have been shared with provider communities.

Joel Johnson: Remember this under the understanding that those are the rates. There isn't a difference in published rates versus lookup tools or anything like that. Because there was a disparity before, which is why we ended up getting those retroactive payments. And they all made good on those payments and we're very grateful for that, but I just want to make sure, there's no speed bumps on implementing that when the ACOs were to take over.

Scott Whittle: Yeah, agreed. I just wanted to throw out that collaboration of care model we're looking at, you know, there's a reason we're mostly not familiar with it primarily lives on the medical side. And so those of us in this group are going to have a ton of contact with it. So just a small bit of background on that to maybe help us kind of point us in the right direction that both Intermountain and the University programs have committed deeply to the COC program. Over a decade of commitment to it. The deployment has been relatively small because of the complexity of standing it up and there is a human resource challenge there, but there are very clearly experts in the space in the community that we can connect to who are still very motivated. And I believe, you know, justifiably motivated to get that program stood up because it is a big piece of the solution I believe. And so that's something I've been neck deep in for over 10 years. So any support or help you want connecting to any element of what's been done in the state of that area. Very happy to play that role and to help get anybody up to speed.

Brent Kelsey: As I look at this and I've been involved in these discussions for a long time and thinking about it in terms of TAM is sometimes kind of difficult because I really believe that integrated care for individuals with substance use disorders is a wonderful thing and it will help solve the access problems we have. If the entire healthcare system is focused and addressed on these issues, right? And I think the same thing is true for mental illness, but when you read this brief that I put out, one of the things that it says very clearly is that there's a population and it's about 20% that need specialty care, which most of the providers on this call represent, right? And they are essentially specialty care in this model.

And I think about TAM and I'm like that's kind of the population. I mean so it we haven't defined TAM in in clinical terms, is that 20%? But in many ways, it's pretty consistent. And so I think we have to keep that in mind too. Integrated care certainly has a role and is the solution for a large part of the population, but we have to get that right. We can't put the wrong population in that model.

Scott Whittle: Thank you. You're exactly right. In fact, that model is a whole list defined as moderate to mild and so it is largely for TAM. It wouldn't be appropriate at all. But I think that goes back to what you brought up in the very beginning and others brought up at the beginning was the reverse integration strategy of taking medicine and pushing it into behavioral health because that's the medical home for most of the folks that receive TAM type services. So, I think if you combine those two ideas, you really start to develop a powerful strategy. So, excellent point, Brent.

Jennifer Strohecker adjourned the meeting at 2:54 PM. The next meeting is July 8, 2022 from 1:30 PM - 3:00 PM

Links discussed in meeting:
https://docs.google.com/presentation/d/1PbctKxDzugYRuW4RXvK3otSnI9k85K0v/edit#slide=id.p1
https://www.chcs.org/resource/the-collaborative-care-model-an-approach-for-integrating-physical-and-mental-health-care-in-medicaid-health-homes/