Objective: Evaluate the pros and cons of a Fee For Service (FFS) delivery model with an extensive case management component for the Targeted Adult Medicaid (TAM) population. Subgroup recommendation will be taken back to the broader Behavioral Health Delivery Workgroup.

Topic	Notes	Recommendation
Question about who would conduct the case management (Dept, contractor, LHD, etc.)?	Up for group discussion/recommendation. Providers may be doing case/care management. Doing more than connecting them to medical care. Life activities/needs (driver license, etc.). Same model as Community Health Workers. Need to make sure rapport and trust is developed. Coordination between case manager and provider is key Molina has a ratio of 1:35 members to case managers for their restricted population.	
What are the pros of this model	1. Some case management activities already conducted by the Dept (HCBS populations).	

	2. ACOs already have a case management structure in place. 3. Outreach to members that don't have current contact with providers or plans. Help educate about resources. Help compensate for current provider services to members. 4. FFS has the least barriers for members access to providers 5. Rural members can get access to services in urban areas with fewer barriers. Fewer geographic limitations. 6. One system that meets all needs. Integrated delivery. Easy to communicate.	
What are the cons of this model	1. ACOs already have a case management structure in place. NCQA accredited. 2. Develop a new infrastructure where case managers do not have as much familiarity with individuals. Learning curve. If run by Dept or contractor, the ability to hire, train, competitively recruit, etc. within budget constraints will be a challenge. 3. Eligibility changes would need to	

	be a focus. Members may leave TAM, switch to other Medicaid programs, etc. 4. Scalability. If case managers are hired by Dept, how would the workload be scaled to meet FTE formula without too much or too little. 5. B3 services, like supportive living, not available in FFS as currently constructed.	
Geographic assessment	56% of the population is in Salt Lake County. San Juan has only 12 clients, so it may not be feasible for 1 FTE. How to staff appropriately. This population has very small rural distribution. Need to consider client's ability to travel and receive care in different counties, with potentially different delivery models.	Staged approach - see timeline for implementation. Rollout to members in counties that do not get one of the other 2 delivery models. Allow the members to learn access points and what services are available. Inform consumers how to navigate resources to address their needs. Help members navigate the health delivery system to allow them to have better access through other Medicaid models. Consider the patient experience to reduce fragmentation and increase integration.
Population assessment	Many members don't have a data plan that allows for telehealth. Need to make sure FFS model could allow for a data plan that pays for telehealth.	No segmentation. Same delivery model regardless of TAM subgroup or condition.

	Audio only? First Step House used an ARPA grant to allow members to utilize telehealth.	
Proposed timeline for implementation		Geographic distribution for all members in counties that do not adopt one of the other two models. Staged approach beginning July 2023 with the continuous ability for other counties to adopt one of the other models over time.
Additional closing thoughts	Any thought about a value-based purchasing arrangement through fee for service? Payment arrangement with limited risk that pays for outcome rather than service. This may be a model in a county that doesn't have large numbers of TAM enrollees, but allows providers to receive payment for services that cannot be translated to a procedure code.	
Meeting September 7, 2022		
Topic	**Notes**	**Recommendation**
Any updates?	Is July 2023 realistic? PHE Unwinding PRISM New Eligibility rules? RFP	

	Waiver amendments Appropriation requirement This concern is consistent across all the options. Are we collectively prepared for what we need to do? Options require various amounts of pre-planning. We need to ensure members are not disrupted in care access.	
What contractual requirements should the Department consider with this model? Ratios? Focus? Home-base?	Fully engaged TAM member that's court-ordered, 1:35 ratio is sufficient. Need a stratification or leveling algorithm to adjust ratios accordingly. For managed care, the restriction program is a good guideline in contract. Well-defined is necessary. Defined criteria for how individuals qualify, how plans report. In-depth reporting necessary. This will be highly visible assuming it will require legislative initiative. What are the outcomes; are we achieving them? How feasible to have case managers in low enrollment counties? Necessitate larger geographic areas. Doesn't require someone in every county. Employ technology solutions, telehealth etc. Interplay between members receiving	Absolutely important to have statewide standards for case management requirements, even if different models are implemented geographically. If a member is already attached to a provider, that provider should be the primary case management provider. Coordination is key. Members should have one contact. Provider's case manager may not be aware of all needs. Not all providers are capable. Case manager would need to be connected to available resources. (Look at JJS hub model aka air traffic control for care coordination) Make sure all parties come together ideally monthly, at least quarterly, to make sure care is coordinated. Inter-disciplinary care team. Member drives and identifies their care team. Requirement of a court liaison, or expertise by

	services in-agency out-of-agency. Who is primarily coordinating efforts? Arizona's system is a well-thought-out model to draw from. Implementation timelines are also established.	case managers. Necessary skillset for case management. Could be technology limitations in very rural, tribal areas. May need some ability to travel. Could potentially have one case manager able to travel along the east side of the state.
What performance measures should we establish for this model? How do we know we're successful?	Make sure the system is capable of pulling reports. Identifying specific goals are met with outcomes. Outcomes report. Per member, identify outcomes met. Goals based on need. Track the member to see when/if goals are met. HEDIS measure, uniform, no need to reinvent the wheel and have inconsistent methods. Behavioral Health Antidepressant Medication Management (AMM) Follow-Up After Hospitalization for Mental Illness (FUH) Follow-Up After Emergency Department Visit for Mental Illness (FUM) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Diabetes and Cardiovascular Disease Screening and Monitoring for People With	Treatment/individual goals met HEDIS measures Social determinants Patient Activation PAM

	Schizophrenia or Bipolar Disorder (SSD, SMD, SMC) Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) Pharmacotherapy for Opioid Use Disorder (POD) Social determinants Housed? Food security? Attached to primary care? Positive trajectory with court mandates? Employment status Earn a living wage Family reunification Emergency services reduction? What are hospitals billing? Examples of primary care directing to ED that turns out to be non-emergent. Time of day is also important. Is that the only access point for that time of day? Patient Activation Measure (PAM), an evidence-based tool. There is an expense. PAM tool Overall success, members no longer needs TAM. May not go directly from TAM to the Marketplace. May lose dental care.	

	Look at what next, and make sure there is continuity of care.	
Enrollment in individuals involved in criminal justice. What outreach is being done? Enough? The department is engaging with corrections to build that further.	Prior to COVID, Odyssey House was working through CATS program to ensure clients were prepared to enroll in Medicaid prior to release. Need to have a meeting with DWS to improve the pre-release enrollment coming out of jail.	
Would like to see program where		

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