Utah Department of
Health & Human Services
Integrated Healthcare

Behavioral Health Delivery Workgroup
Meeting Minutes June 10, 2022

Participants

Committee Members

Adam Cohen, Jed Burton, Jennifer Ford, Representative James Dunnigan, Scott Whittle attending for Joel Johnson, Julie Ewing, Dr. Katherine Carlson, Kyle Snow, Patrick Fleming, Russ Elbel, and Brian Monsen attending for Brandon Hendrickson.

Committee Members Absent

Senator Michael Kennedy, Jake Shoff, Lisa Heaton, Tim Whalen, and Nina Ferrell

DIH Staff

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

Attendees

Eric Barker, Travis Wood, Gregory Trollen, Janida Grima, Michael Hales, Rachel Craig, Todd Wood, Stephanie Burdick, Eliana White, and Matt Hansen.

Welcome

Jennifer Strohecker opened the meeting up and welcomed everyone. Today's meeting will be one-hour, future meetings will be an hour and a half, so we can have more time to dive into issues and have the robust discussion we need to have.

Review of Last Meeting Minutes

Jennifer reviewed the minutes from the last meeting, starting with introductions and affiliations.

Approve May 25 Meeting Minutes

Patrick Fleming makes motion to approve as presented, Jed Burton seconded, motion passes to approve minutes.

Outstanding Operational Issues

We would like to recognize and vocalize our appreciation for your willingness to share your concerns and issues that were brought forth at the last meeting. We know that you do have concerns and we have taken a look at these concerns. We understand that with regard to the global issue of reconciling the discrepancy of the rates, we have reached out to our ACO partners and they have provided written feedback to Medicaid, reporting they have updated the rates and re-processed all claims. We do recognize that there were some individual billing issues where perhaps inappropriate NPI was billed or some claims processing had been identified and those issues are being worked through one by one with those of you who have identified that this has happened. We are working through those with you. We wanted to just clarify this global issue of rate discrepancy that happened several months ago should be addressed and resolved as far as the larger issue.

The other piece as well is some other information we found as we evaluated the concerns that have been brought to Medicaid's attention. First and foremost it is our priority to have your things paid and to have them paid timely. There have been a couple times this week brought to our attention about communication that had occurred between the behavioral health provider and the ACO where an amount of dialogue went back and forth, where Medicaid had not been engaged. We would encourage providers to engage with us in a timely way so we can help you with these issues. While we know you may be able to work these out between you, if there is an issue where you are unable to successfully resolve an issue, please engage us in that conversation so we can help facilitate, we can look at the claims, we can evaluate what the claims processing issue is. If it's a larger issue we want to work on that with you as well.

Another item I just wanted to update you on is also our updated rates. There was a communication that was sent out last week as well, that communicated our July 1st rate updates for both residential treatment and also for our methadone rates, the daily rate for methadone administration. An email was sent to both our accountable care organizations and our prepaid mental health plans that would notify you that these rates have been updated and will be live in your system on July 1st.

Any questions before we move on to our next topic?

Patrick Fleming: A question I would ask, the ACO's I believe have contracts with most of the governmental agencies that provide TAM services plus most of the private/nonprofit or private/for profit agencies that provide TAM services. Is that correct?

Russ Elbel: Yes we have contracts with the providers to date that provide TAM services. Medicaid did an assessment of that, did a GAP analysis six months ago and we have the majority of providers. We are closing the gaps on those we didn't have.

Patrick Fleming: The one thing I would suggest then is if we have contracts, especially now with the governmental agencies, they have reserves where they can afford to miss a couple

payments and still make payroll but a lot of the private non-profits, they don't have that kind of cushion. That really is the issue. I would like to suggest this, since the ACO's have contracts with everybody and it's a long-term contract, why don't we pay the claims when they are submitted and then we can go back and reconcile those later on. Why hold up all the claims for reconciliation when we're looking at making payroll?

Jennifer Strohecker: Thank you for sharing your thoughts on this, we will take this back for a conversation, and we will bring it back.

Identification of Services the TAM population Utilizes

A. Provider Input and Data Review

Brent Kelsey: We've had a lot of internal discussions on how to structure this meeting to get us moving in a direction toward figuring out long term what we do with targeted adult Medicaid (TAM) and I've been really pleased with the discussion internally because I think we're in agreement that the best way to structure this is around the needs of the client and what in the best interest of the client, how do we develop a system that truly meets people's needs and I think that having worked with so many of you on this call, I think most of you, if not all of you, would share that perspective. I think what we want to do in this next section, and this is going to be contingent upon your participation, is we want to identify those things that are working successfully in TAM from both a physical health care and behavioral health care perspective.

In the last meeting we shared with you a tremendous amount of data about diagnosis and the services that are received and as a reminder you saw a tremendous amount of data on chronic conditions within this population; diabetes, pneumonia, hypertension, depressive mood disorders, substance use disorders was the leading chronic disease found in this population. We also know that this population is receiving services through pharmacy, primary care, substance use disorder treatment providers, mental health providers, and the emergency rooms. This is a population that is really hitting all elements of our healthcare system. I guess what I would ask to kick things off today is, in terms of physical health and managing the conditions that you are seeing in the TAM population, can a provider or ACO or a member of this committee identify some of the strategies that you think are critical to successful management of the targeted adult Medicaid population (TAM)?

Patrick Fleming: I think one of the key things is really good sound case management. These individuals have a hard time negotiating and a good case manager with some innovative ways of getting people into services is really important.

Katherine Carlson: Access, building on what Pat said, the population has difficulty navigating various systems, even accessing our system where we may have more skill or more ability to be flexible. I think a strategy that understands the difficulty in access is important. It can come down to nuts and bolts things like scheduling and availability.

Janida Grima: It is really difficult to engage this population in preventative care. Some of the strategies that we have found to be successful have been touched on a little bit. A significant amount of work from case management and care coordinators around targeted event type days, so we do a men's or women's health day. Our case managers and care coordinators do a lot of combing in our records for that so we can be flagging who hasn't been in for a few years so there's a lot of outreach on the back end.

We use our community advisory board, it could be a peer support role, to be able to do some of that outreach to do some education with people on why you want to come in and do your test or get your physical. In that process we give away a lot of hygiene stuff, a lot of women need feminine hygiene products, clothing, and similar items that you need as a woman.

Patient incentives are the other part of that, and we know that's tricky with Medicaid, but being able to offer a gift card to a grocery store or something similar can get people to be more interested in coming in for some of those preventative screenings. Knowing we have a disposition for them after, for example if we do a test and we know there's a potential for a colonoscopy coming up, understanding where that individual can go for that service, which is more a barrier for uninsured, oftentimes the prep for that is really difficult, if you are living on the street or in a center, you are not going to be able to do the prep for that so we will put patients into a hotel to help them get ready for that procedure.

Russ Elbel: I just wanted to build on the comment about care coordinators. Another piece we've added into that is community health workers and utilizing them. When we have trouble connecting, we can utilize the community health workers who can help find them in the community and their role is to assess not just their physical needs but their social needs as oftentimes that is what is preventing them from addressing physical and behavioral health needs.

Julie Ewing: Echoing this concept that care coordination is key. One of the things we have learned while the individual is still incarcerated the jails are doing risk assessments on folks and this assessment is a very thorough risk assessment and as we are looking to implement these programs one of the things I would suggest is if the ACO's could get access to those risk assessments the jails are already doing because then we can see what some of the needs these individuals have. The other piece I would love to see this group talk through is when an individual leaves the jail their application for TAM can't process or be submitted until they've left the jail. What that leads to is a gap in coverage for the member for the first couple of weeks. When those individuals are leaving the jail is when they need that care the most, they are only given a 15-day supply of medication, they have transportation issues and with that gap in coverage, I would love to see that change and see if we can get applications processed before they leave that way we can step in immediately and we don't lose touch with them. We can have the jail hand them off to use

and we can take it from there, otherwise what we might run into is a couple weeks out you lose sight of the member and you're not able to connect with them.

Eric Barker: Some of this stuff may iron itself out a little bit. We work directly with individuals coming out of the prison system. Typically, there's about 3000 to 3500 individuals to get released every year and a lot of those will qualify for TAM. I wanted to speak a little to what Julie talked about. Like she mentioned about the jail, we do a very comprehensive risk assessment as well and those are things that we can work together with other medical providers. One thing we have worked with on TAM is those individuals that are a serious risk, we actually roll the dice and get those applications for TAM submitted early but we have to be careful with the dates.

Scott Whittle: There may be some solution in creating a sub-contract but one of the big concerns that we have about the whole health model of care is that we have to penetrate much deeper into the mild and moderate needs. One of the reasons we needed TAM to go fee for service was because of the access issues that exist within our system as a whole. I think an issue like expanding services or filling in gaps really requires an all willing and qualified hands-on deck strategy.

Adam Cohen: What we're seeing when people come to the door is that this population is very marginalized and not really accessing services in primary care or behavioral health care. In most cases people coming to the door are coming with the clothes on their back and for some in the criminal justice involved, they are coming in with tattered clothes because of an altercation with police, or maybe out of date for seasons. We're starting from basics with these individuals, they don't have a driver's license or social security card so we're having to walk them through all the basic things we all take for granted. Pivoting back to the primary care discussion, they haven't really accessed health care in any meaningful way in many years so rapport is huge.

Brent Kelsey: I know there's a lot more that this group can bring to the table in terms of successful strategies, and I hope that we can continue this discussion going forward. The other question we wanted to pose to you today, and the bill poses to us, is about defining success and how should we define success with this population? As we talked about it internally SAMHSA provides guidance to our system about what recovery looks like or what success looks like in terms of behavioral health, and they've defined recovery and the elements of recovery in terms of health, home and purpose. Who has some thoughts as to what the plan should be for targeted adult Medicaid? What should we really be paying attention to?

Katherin Carlson: It's harder for me to think of metrics in terms of specific cases or specific agencies, even though we are all trying to accomplish the same end goals, people enter the system and focus on certain pieces of their health issues. I think if we had access to, you know if treatment reduces hospitalizations for a one or two year period, does it reduce ED visits. I think we need that long view as opposed to patient satisfaction or

completion of a treatment episode. What is happening to this person in terms of the larger health care system that we can't access as individual agencies or providers? I think hospitalizations are a big one, mortality, housing, justice involvement.

Q&A

Jennifer Strohecker: This is not set dialogue, what are our metrics for success? One of the things as we've met and thought about what our goals are is to really remain whole person centered and what the needs are for this population. What are some things our data isn't showing us, what types of wraparound services, what are these metrics for success around the unique needs of this population, that we need to think about?

Rep. Jim Dunnigan: As a follow-up to the last meeting there was some wonderful data on utilization. We asked for some more specifics like the emergency department and things like that. Has your team had a chance to evaluate that and if we don't want to take time in this meeting or the next meeting to go through it, could someone send more detailed information out so we can get a better understanding of the utilization?

Brent Kelsey: Brian Roach will be sending this out with the minutes.

Jennifer Strohecker adjourned the meeting at 3:02 PM. The next meeting will be an hour and a half, in two weeks.