Utah Department of
Health & Human Services
Integrated Healthcare

Behavioral Health Delivery Workgroup
Meeting Minutes May 25, 2022

Participants

Committee Members

Adam Cohen, Jake Shoff, Jed Burton, Jennifer Ford, Representative James Dunnigan, Joel Johnson, Julie Ewing, Dr. Katherine Carlson, Kyle Snow, Lisa Heaton, Patrick Fleming, Russ Elbel, Tim Whalen, and Nina Ferrell.

Committee Members Absent

Senator Michael Kennedy, and Brian Monsen attended for Brandon Hendrickson.

DIH Staff

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

Attendees

Alan Pruhs, Audry Wood, Beth W. (Unknown Last Name), Daniel Sloan, Eliana White, Janida Emerson, Matt Hansen, Michael Hales, Rachel Craig, Todd Wood, and Travis Woods.

Welcome

Jennifer Strohecker opened the meeting up and started introductions.

History of the Targeted Adult Medicaid (TAM) Population

Nate Checketts gave an overview of the history of the TAM population.

The TAM Population Today through Review of Utilization Data

Brian Roach went over the utilization data going back to November 2017.
The document which was present is embedded in this document.

Targeted Adult Medicaid Summary 2

Q: Katherine Carlson - Do you have a further breakdown of the cost on the physical health side, what portion is hospital, emergency department, outpatient, pharmacy (ED), etc.? And the same on the behavioral health side?

Brian Roach asked if it would be helpful to see that data by per member per month? Katherine was uncertain, maybe by aggregate annual costs. Interested in where the high costs are in order to distribute the cost in a way to get better outcomes. Russ Elbel commented that aggregate cost would be useful but also per member per month across the different groups would be helpful, as well as trend over time.

Action Item: Division to provide the data above.

Q: Representative Dunnigan - Interested in the information for the hospitals. What the ED is for hospitals and what the encounters are for ED. In regards to the $1205 Per Member Per Month (PMPM) how does that compare to the expansion, can you get that for us? Brian Roach mentioned there is a difference between the non-TAM childless adults and expansion. It is around $1,000 PMPM, parents are around $500 or so. Brian said he can get more specifics next time.

Action Item: Division to provide the data above.

Representative Dunnigan - I'm interested in why there is so much arthritis among young people?
Katherine Carlson - We should be asking what is accounting for hypertension for this age group.
Representative Dunnigan - Does their lifestyle age these folks and explain why they have these conditions at a young age?
Jennifer Strohecker - If you look at the utilization of medicine, unusual profile with this age group perhaps it is a lack of continual care? This is a high level look, but can provide more information if it is of interest to the group.

Q: Nina Ferrell - Is it possible to get data on the types of behavioral health care these folks have had before they needed a higher level of care? What services did they receive before they hit the acute stage or before going into a hospital did they have another service or seen another provider? Interested in analyzing which programs are most effective at which stage. If a member is suddenly acute and put in an inpatient unit perhaps we could look at the building blocks to prevent that and what the data is saying early on. Which ones are helping and which ones are not.

Action Item: Division to provide the data above. Brian cautioned that this data may not have the entire picture based on elements we have pertaining to the data.

Russ Elbel added to the chat box: Brian, the encounters per 1000 would be useful so we can compare that to other populations

Q: Janida Emerson - Curious on the hypertension diagnosis, are they coming through the ED or primary care providers?

Action Item: Division to provide the data above.

Q: Adam Cohen - Has the PMPM changed over time? Is it related to people not rolling off the program? Typically we see members, get them on the program, they receive treatment, get a better job, and then leave the program. Will this be accurate once the PHE ends?

Brian Roach - yes it has decreased a little bit during the pandemic. The PHE has been a factor. In the MCAC meetings the raw numbers included expenses that Medicaid receives a rebate on. Some of it is reduced when accounting for pharmacy rebates. The PMPM has decreased during the PHE.

Katherine Carlson mentioned what is the nature of these costs. The first year is sometimes where the highest cost occurs, then decreases over time. It would be good to get a look at a timeline of costs.

Framework of House Bill 413

Representative Dunnigan went over the framework of HB 413. The TAM population started as Fee For Service due to demand in the population and didn't know what the fair or adequate rate would be at that time. But we have that data now. This population requires a lot of care and handling. Should TAM be folded into the ACO, and if so, when, and under what criteria? We have a shortage of clinicians, and am concerned if we would lose providers and are the ACOs fully cognizant of the needs of this population.

Brent Kelsey went over the goals and objectives in House Bill 413. This workgroup needs to decide how we want to begin working on these issues? We need to be strategic and thoughtful and creative about how we address the tasks in front of us. If there is additional information you want to see, let us know.

The document which was present is embedded in this document.


HB0413.pdf

Starting on Line 152:
(2) On or before May 31, 2022, the department shall convene a working group to collaborate with the department on:

(a) establishing specific and measurable metrics regarding:

(i) compliance of managed care organizations in the state with federal Medicaid managed care requirements;

(ii) timeliness and accuracy of authorization and claims processing in accordance with Medicaid policy and contract requirements;

(iii) reimbursement by managed care organizations in the state to providers to maintain adequacy of access to care;

(iv) availability of care management services to meet the needs of Medicaid-eligible
individuals enrolled in the plans of managed care organizations in the state; and

(v) timeliness of resolution for disputes between a managed care organization and the managed care organization's providers and enrollees;

(b) improving the delivery of behavioral health services in the Medicaid program;

(c) proposals to implement the delivery system adjustments authorized under Subsection 26-18-428(3); and

(d) issues that are identified by managed care organizations, behavioral health service providers, and the department.

On line 194:
(4) The working group convened under this section shall recommend to the department:

(a) specific and measurable metrics under Subsection (2)(a);

(b) how physical and behavioral health services may be integrated for the targeted adult Medicaid program, including ways the department may address issues regarding:

(i) filing of claims;

(ii) authorization and reauthorization for treatment services;

(iii) reimbursement rates; and

(iv) other issues identified by the department, behavioral health services providers, or Medicaid managed care organizations;

(c) ways to improve delivery of behavioral health services to enrollees, including changes to statute or administrative rule; and

(d) wraparound service coverage for enrollees who need specific, nonclinical services to ensure a path to success.

There may be other issues to bring to the table such as this concept of Certified Community Behavioral Health Providers. Other states are moving in this direction and may likely need to discuss in a future meeting. Do we want subcommittees? Are there priorities we need to address first? What would be the most effective way to start tackling these issues first? Jennifer Stohecker added: What are some known issues or barriers that exist? We would like to hear what works and what doesn't work and what is your experience so far?

Tim Whalen - At the county level, we are managing a legacy Medicaid product. There has been an increased presence of TAM consumers, and needed to utilize other dollars to help with care coordination. The program cannot drive how the mental health court is run. This population is highly criminal justice involved and as we move to captiating this into the ACO structure, we need to make sure there is care coordination and members would need help in navigating this.

Adam Cohen - Two issues we need to tackle. 1. Payment - Need to ensure payments are happening as promised. We are having issues receiving the rate increases from last July 1st (receiving the back pay on the new rate) and there is another rate increase coming soon in July. 2. The true complexion of the population - what a positive outcome treatment is and what level of care to ensure we are not creating more barriers for these members.

Janida Emerson- There are a couple of different layers of integration being discussed. Integration of the payment at the plan level and the service/provider level. We need to make sure the providers are set up to handle the need and have experience to handle this population and members receive the outcomes we want.

Lisa Heaton - The purpose of this workgroup is helping in communication to make sure this works like a well oiled machine as everyone wants these to work. In building this bridge it is difficult to handle the bigger issues when we have other issues like the payment issues that need to be resolved. How do we resolve the issues in a real way with the ACOS and bring the focus back to the client.

Dave Wilde - TAM has an integrated benefit currently but they don't have a care management component. Maybe we look at different solutions and other models out there. What other types can fit this population better?

Russ Elbel - Cell phone number in the chat for those with issues with payments from Select Health. In the bill there are clear metrics that can be developed there - managed care

compliance, EQRO audits is a great way to look at these. Timeliness and accuracy of claims processing metrics, and reimbursement from the ACOs. Generally we can come up with metrics that already exist and determine if we are meeting these metrics.
Brent Kelsey agreed and stated we should work better as payors and can release the burden to providers that we have today. We want to work with you to help align the requirements with the rest of the payer structure.

Nina Ferell - Part of the reason to be on this group was to have a voice for the disconnect from the acute inpatient. We have billing issues, because it is a FFS program. Examples of barriers are: we get denied because we didn't get a pre-cert, but when calling told we don't need one. Also billing codes or billing for bundled services are an issue. Providers will not take TAM anymore due to these types of billing issues. Acute care does a terrible job of working towards social determinants of health. Would like the workgroup to work towards helping community providers with lasting results.

Jake Shoff- Recognized the previous issues such as payment, access, and utilization reviews. A lot of the administrative items are the big problems we face and we need to solve these issues first and then can move forward. There is a trust issue with the ACOs and the providers. In the solutions lies the remedies for what it is we need to go forward. Would like a status update from the ACOs about where they are on payment, retro-active, and the one coming up in July. Suggested the next meeting to discuss these solutions.

Joel Johnson- What we are doing here is the reimbursement mechanism at its core, the clinical and medical integration come second. Need to identify correctly where the dollar flows. Regarding the retro increase, how do we identify how it is coming across, is it tied to a payment or a claim, etc? Joel added these items in the chat box:

- Thank you for the opportunity to touch on some of those things. I'd like to reintroduce these specific points as far as requested deeper dives.
    - Retro Increase back to July 1/2021 to match FFS increase.
    - Are there plans to bundle more rates in addition to the residential rate?
    - Maintaining the bar set by FFS during the implementation period.

Adjourn

Jennifer Strohecker adjourned the meeting at 10:00 a.m. The next meeting is scheduled for Friday, June 10, 2022 at 2:00 - 3:00 p.m.