Objective: Evaluate the pros and cons of ACO 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.

Notes: **What version of managed care is considered? UMIC plans, ACO's, PMHP's? -

Topic	Notes	Recommendation
Geographic assessment	56% of the population is in Salt Lake County. 1. Original conversations focused on ACO model piloted in SL County 2. Consider 4 Wasatch front counties	UMIC plan counties - although note that SL County and other counties do have operational differences **Proposed to add Morgan, Summit, Tooele **Consideration that the population could shift between categories of eligibility and alignment of services (i.e. UMIC counties) could be advantageous to this population-supports continuity of care.
Population assessment	(for example: SMI, substance users, young, old considerations, criminal justice system involved etc.) 1. Differentiate by population? 2. Consideration that dividing by subgroups would result in difficulty in measuring impact 3. Individuals shift w/in subgroups and holistic approach is best	Manage as a whole TAM population w/o any segmentation
What are the pros of this model	1. ACO's have a robust care management staff w/ flexibility for growth (noted that current FFS	

	model does perform case management today) 2. True integration at the provider level...not just the payer level 3. ACOs have a line of sight into cost drivers from multiple angles 4. B3 service access 5. Supports continuity of care as members move between Medicaid programs 6. ACOs are known entities with established systems w/in the state 7. Could address geographic limitations 8. ACOs can be more creative in how care is managed 9. Complementary management of BH/physical health issues	
What are the cons of this model	1. Some ACO's are vertically integrated and some are not-contracting challenges 2. UMIC challenges on the payer side vs current FFS model. 3. FFS reimbursement vs. ACO model at lower reimbursement w/ greater admin burden* 4. Financial structure of reimbursement w/ ACOs today	

	doesn't capture some of the additional services delivered that are essential but have lower/no reimbursement 5. Providers have to bill multiple entities instead of one 6. May shift some burden of care to LHD's/LMHA's 7. Limitations of current ACO benefit design does not support creative/strategic expansion of service delivery to meet needs *Note could address some of these cons w/ greater provider engagement in the ACO model. Additional structure that aligns incentives for providers / payers	
Proposed timeline for implementation	Slow and methodical implementation to address any challenges w/ delayed reimbursement (TAM population is critical revenue and delays in reimbursement cannot happen)	
Question about who would conduct the case management?	1. Does it happen at the service point or at the ACO level? Collaboration between case managers in different settings is essential. 2. Need to work out reimbursement for case management services that	

	are not billable	
What are the contractual outcome measures	1. Contract language that creates greater provider engagement in the ACO model. Additional structure that aligns incentives for providers / payers (Dr. Whittle to provide additional info) 2. Careful benefit design that allows some flexibility to address needs	**Detailed services / quantities / and assignments that address the needs of the population. *Non-covered Medicaid services can be covered under the administrative rate *Clear reimbursement language that supports goals and objectives **contracting flexibilities can be applied/included ** Let contract language be driven by population and system needs

Julie- run a report on the Expansion pop to see who was previously on TAM to better understand the pop that is being serviced through ACOs now.

Notes from Sept 12

2022-09-12 Notes

In the HB413 meeting held on August 19, 2022, the subgroup was tasked with determining the “must-have” items that would need to be incorporated into the ACO contracts if the TAM population were moved to being covered under this model. In addition, we need to provide suggested outcome measures for each of the suggested contractual requirements.

Requirement	Description	Outcome Measure
Specified ratio of care managers to members	Each ACO has a different structure for this. There needs to be flexibility in staffing this based on how each ACO accomplishes this. Division will not disrupt any existing care management relationship.	Are members staying out of the criminal justice system? Are they staying in treatment? - There may not be a good way to track if a member is in or out of the system. New reporting will be required from corrections.
Expansion of the essential provider list		Not necessarily a specific measure for this one.
Higher level reimbursement for essential providers		No specific measure here.
Risk dimensioning on the top 1-5 percent	Ensure that the most medically complex people’s needs are being met. Create a list of specific members (25 - 30). This may be hard to implement due to the differences in software used by each of the ACOs. Might need to have a collaborative discussion between the ACOs and the state. Have care managers	Potential measure of what the ACO’s have done to reach out to members who are newly eligible.

	proactively reach out to members who will fall into this category.	
PA Requests and Review	Consistency across all ACOs regarding prior authorization reviews. Need a plan to target the appropriate dose and treatment.	Turn-around times for PA review and outcome / claim processing.
Align incentives or providers and payers with the contracting		Ex: transitions, collaborations, social determinants.
Engagement with non-utilizers		
Adherence outcomes	Engaging providers who support interventions to promote adherence, specific adherence interventions/outcomes	
Timely payment of claims	TAM is paying within days of submission today.	
Formalize the process of how providers can utilize OMH to resolve issues between themselves and ACOs.	Add a timeframe for which such problems will be resolved and a potential fall-back if the timeframe cannot be met.	
Subcapitation as a potential payment methodology.	Pay by episode of care, rather than by individual claims.	

Interventions or models that support continuity of care / transitions of care	Enroll members automatically into the PMHP in the non-integrated counties.	
Consistent UM policy across plans / collaborative UM policy development and management	Supports member transition across plans. Could use the Clinical Collaboration Committee Meeting for this purpose.	

Need to have statute that requires the criminal justice system to report back to DHHS in order to accomplish the above potential measure.

Due to the small population size of the TAM population, the HEDIS and CAHPS measures may not be accurate.