Western Region Managed Care Organization Work Group

Tuesday, July 20, 2021 @ 11:00am

I. Welcome and Introductions

II. Purpose of Work Group
   a. Review of Workgroup Charter

III. Prioritization of Issues
   a. Reviewed survey results (about ½ of members were able to respond successfully)
   b. The survey showed the top 3 priorities as:
      i. Cross-system coordination of care
      ii. Develop efficiencies in healthcare delivery system
      iii. Improve health / behavioral health outcomes
      iv. Discussion:

IV. Discussion

Question raised as to how can we do any of these without funding? Response: Let's focus on what we want to do, then come back to how to fund it.

We need coordination of care to improve patient care. Need improved data and information sharing for better outcomes. Need easy access to data.

Extra resources (care coordinators, nurses, office managers, etc.) could help coordinate care while we are providing direct service. Different terms have different meaning for care coordination. But not all payers will reimburse for that. It takes time to coordinate care. It holds people in the hospital, especially those who do not fit neatly into care boxes. Ability to coordinate care is not a billable service for behavioral health providers if the patient is not in a health home.

We run into blocks trying to coordinate care (ie: no one will accept a client for residential services) even though we put a lot of resources into trying.

Access to care hits a roadblock if people don't fit neatly into a box.

We need to create a job, and pay well, to coordinate care. Trained navigators would help, but are not billable.

Different insurances cover different resources. It takes a lot of time to get reimbursed. Outcomes get reimbursed.

We need to address all these things regardless of reimbursement.

Medicaid new coordination of care is high on list.

Health Homes are doing great and move measures with Medicaid.

Health Homes and plans have a mutual dependence.

Health Homes have a great model, but not everyone qualifies. Value-based reimbursement is difficult to measure who was successful and who gets what. Also, we don't want to wait for a crisis, we want to help before a crisis.

Develop Rising Risk models to engage members and avoid crisis.

Significant conversation re: HIPAA and Plans being able to obtain the information from providers that is needed. HIPAA can be a barrier to communicating, but there are exceptions to HIPAA.

Barriers between PCP's and BH providers. PCP's often make the BH referral and consider their role complete. There is lack of follow through on the PCP's behalf and often times, zero communication between the PCP's and whom they referred their client to for services.

Difficulty establishing who is responsible for the patient: the PCP or the BH provider. Highmark came up with a great model. They will share it with whoever is interested. PCPs are the attributer of the patients. This model helps make the BH providers work more closely with the PCPs.

Andrea discussed her newly developed provider attribution plan from Value Network. They came up with a model to delineate costs.

It is very difficult to figure out how to bucket members and develop payment mechanisms.

Try to move the system from a reactive system to a proactive system for all payers.

Attribution and data sharing are top issues in coordinating care.

Developing VBP based on data.

Plan: Are there other things going on that we can help with? Working with hospitals more would help. Clients are being treated at hospitals for medical issues, but their BH issues aren't being treated. Post-discharge BH treatment is important. Working with hospitals developing a way to look at them beyond the medical issues. Connectivity to Behavioral Health is a big issue. Work with hospitals to ID and connect better.

We have care management programs – we try to reach out. Ability to coordinate with provider & Plans are barriers, ie: HIPAA.

Some barriers discussed re: high utilization and follow up care were transportation and critical needs not being met. Transportation examples were that the client does not have the transportation, does not know how to obtain transportation or the services may not meet the requirements for utilizing the Medicaid transportation services.

Critical needs were identified as housing, clothing, food, personal hygiene items and means to get their medications.

Better discharge planning and transitional care is a hot spot.

ECMC is working on decreasing barriers, ie: CPEP's high utilizers.

ECMC is expanding the Help Center hours.

There was conversation re: the end of DSRIP and the initiatives that were started with that funding and the difficulty some are facing trying to continue those initiatives without DSRIP funding.

NFMMC is still doing hot spot work that started from DISRIP. projects (some were funded, but then de-funded, so they ended), etc.

Often care coordinators from payers just ask if the patient showed up for their appointment. They might be able to help more.

If we spend some money on things like transportation, that would help.

New crisis teams and the use of peer services can be really helpful to prevent an ER visit or crisis, reducing recidivism.

What is the future of Peer Services?

MHA has peers. They don't replace staff. They decrease recidivism. They have a new team of peer and professionals.

The social worker / peer combination is working great.

Note: Due to the conversations and the great engagement of all on the call, it was asked if the next call should be made longer to be able to allow for more detailed conversations on each topic. Most supported a move to a 90-minute format.

V. Open Agenda

VI. Meeting Schedule

a. Next Meeting: Tues, Aug 19, 2021 @ 11:00am – 12:30pm