March 15, 2017 UCCCN Learning Session - Summary

	Healthy U	Molina	Health Choice Utah	SelectHealth	Pediatric Specialty Services
Learning Session Panelists (Insurers)	Liz Armour-Roth, Manager, Care Management Nancy Cunningham, Utilization Management Pediatric Case Mgr	Sheila Young, Director of Healthcare Services	Brandon Sandall, Supervisor of Health Services Geri Wadsworth, Complex Care Manager	Chris Chytraus, Health Services Manager Scott Whittle, Medical Director	Seth Andrews, Administrative Director
Care Management # and website	**801-587-6480 opt 2** for Care Management	Call Molina Health, **1-888-483-0760,** choose Member Services, ask for Care Management. Also, the Care Connectors in your office (weekly or monthly)	**1-877-358-8793, opt 5** for CM team or healthchoiceutah.com for Case Mgt form (goes directly to Brandon)	**801-442-5305**; press #2 for Medicaid, #4 for commercial. Ask to speak with a Care Manager for Pediatrics	(PSS will contact you)
Panel I Questions	**Healthy U**	**Molina**	**Health Choice Utah**	**SelectHealth**	**Pediatric Specialty Services**
Number of Care Managers	4 pediatric care managers	65 CMs, not distinguished between adults & kids. Focus on Asthma and Diabetes	4 Utah CMs, each specialized. Very small local team - Complex case mgr RN, Beh Health	6 pediatric CMs - 3 on Medicaid, 3 on commercial. Disease management CMs, Healthy Beginnings	Set up to take alternative payment. Partnering with payers to cover certain services.

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		on Disease side, other conditions on Complex Care	LCSW, Maternal-OB CM, Disease CM, some concurrent review nurses (continuum of care)	follows newborn to age 1, pediatric, adult, and restricted (overutilizers)	Primary Children's has 65-70 FTE CMs; PSS will have 2
CM Primary Functions	One focuses on transitions and decreasing ED util; PDN and Asthma; two that work on complex kiddos (plus Asthma pgrm), one coordinator	Some CMs have more experience with children. Transition of care nurses. Complex care management - high risk pts. Disease mgt (diabetes & asthma). Community Connectors - work with/in clinics (weekly) - 2 way communication and integrated care mgt	CMs in AZ provide support - 9 FTEs functions are around CHEC (kids).	Utilization review done separately so CM can carry higher case load. One-on-one support, work closely with care coordinators in clinics. Work together upfront to id items that are covered.	Care Coordination Connector Service - aimed at 1% of patients who use up 30% of costs. Longitudinal care thru needs assessment, SPoCs for whole care team, escalation plan, family goals.
Success Measures	Relationship-based pgm; monitor patients across continuum. Quality services at an efficient cost. ED util, readmission from hospitals, customer satisfaction	Data: Utilization for inpatient /out-patient, ED, high cost, etc. Watch for decreases in utilization of in-patient services. Codes:	NLR, ED utilization, HEDIS measures	NCQA requires data. They do surveys and other gathering. Member-centered goals. Social determinants are addressed. Finding providers, setting up appts. Costs before and after care mgt. ER utilization.	Primary Children's Foundation has funded a randomized clinical trial - 2 year study to compare CSHCN through a control and intervention groups. Cost, utilization and family experience of care - metrics.

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				Meeting goals.	
How Patients are Identified	Monitor patients across continuum. ED utilization, readmission from hospitals, from practices	Community Connector program helps identify patients for clinics and get referrals from clinics	Reporting tools: utilization patterns, cost, in-patient members (working with hospital partners and medical director)	Multiple: self-referral, info by utilization nurse, internal surveillance reports, provider referrals, ED reports, readmission.	Hasn't begun yet but the clinic and the payer's care manager will be contacted by PSS early on - must have a SelectHealth or Healthy U plan that PSS is contracted in (SelectHealth is both Medicaid and commercial plans). Don't want to duplicate services offered by insurance companies. Focusing on patients that become in-patient and have medical complexity. A small number (maybe 400 over 2 years). Just adding incremental resources for the MOST medically complex kiddos.
Prior Authorization	See University of Utah Health Plans website - utilization guidelines. Talk with	On Molina website and patient portal. Covered codes. Also, Community	Direct communication from network representatives to providers around prior	Phone number or web portal.	Want payers and providers to work together to identify what services should

	CM department. They want to have strong connections with clinics.	Connectors in clinics - direct communication.	auth. Website has guidelines and criteria, 1-800# for providers to call.		be provided via what technology for best outcomes at best cost. Some cost responsibility falls on providers.
Denials & Appeals	Appeals department - quick turnaround time	Internal dept that handles these. Normal notification to member AND CMs/community connectors to see if there might be alternatives in the community	Regulated by the state; first step is when a complaint or grievance becomes an appeal, they look internally, then look at getting the ALG involved (fair hearing rights)	Medical review done before denial to review for medical necessity. For Medicaid peds population, 2 step process: - Back for a secondary review by objective physician - Medicaid fair hearings	
Panel II Questions	**Healthy U**	**Molina**	**Health Choice Utah**	**SelectHealth**	**Pediatric Specialty Services**
Help practices ID patients?	Within the U Clinics, they are having care conferences. Can do that with other clinics to discuss complicated cases. Can set goals, do a	Can communicate about shared members about claims and utilization data, foster care kids, Transition of Care prior authorizations.		Metrics, disease mgt models, referrals in from providers and patients.	PSS will be identifying the most complex patients from the 150,000 with SelectHealth and 30,000 with Healthy U. This totals about

	care plan, identify roles to move the plan forward. Pediatric Asthma program helps identify kids. Can come to the clinic to train the trainer on Asthma, or education for families ("Asthma Fair"). Care Management Program handout for Healthy U members.				20% of Utah children
Collaboration with pediatric practices?		Peer to peer; Community Connectors or Case Managers connected to clinics. A lot of the time,Molina may not know what is happening with some of their contracted providers (like DME). If clinics can give Molina feedback, it can be very helpful.	Use the regular channels; they should be effective and efficient. However, you can (for now) just call Brandon. Geri Wadsworth uses the cHIE to find the primary care physician to reach out proactively	To expedite claims for complex cases needs, call the care manager. Would like to expand their footprint in multidisciplinary practices: panel with the kinds of providers you need.	
Codes paid	Yes - on all of the Medicare care coordination codes.	Codes for Medicare population - provider can bill for care they provide for complex	Yes, all 4 codes	Yes - 4 codes are paid in all 7 of their lines of business (commercial,	

		patients. 99490, 99489. Look at the criteria (2 or more chronic conditions expected for 12 mos or longer)		Medicaid, Medicare)	
Other methods of compensation?	Contracts - Provider Relations can help with incentives for quality goals and the HEDIS measures.	Population Mgt: through value-based contracts for quality measures. ICT meetings - the physician can bill for these if s/he is part of the meeting.	Quality metrics, using in network providers, contracts	Mental Health integration, medical homes - aligning care. Special contracts to share the expenses - population health mgt	Intermountain has introduced a new payment model for some of their SelectHealth providers. Mgt of the total cost of care as a whole network (3000 physicians), quality metrics, service standards (satisfied patients) - all get bonuses.
Other Questions	**Healthy U**	**Molina**	**Health Choice Utah**	**SelectHealth**	**Primary Specialty Services**
Families/Consumers input?	Some consumers are on their committees. Do home visits to work directly with families to get services for complex kids; a more individualized	Molina will be starting a Consumer Advisory Board this year. Peds population gets a lot of direct communication. Parents are the experts on their child.	Don't currently have a Consumer Advisory Board but will in the future. Currently, work directly with case mgt team. Can escalate any issues as they arise around DME,	Handled on a more individual basis. Meetings with providers, family members, community partners.	Shared Plan of Care should help identify family needs and will work with them on an individual basis.

	approach to get to the needs	Like to get their feedback. Community mtgs with providers helps. Integrated care mgt. Interdisciplinary *Case* Team (ICT) meetings. Family and all other caregivers (including medical) can participate. Providers can bill for these meetings	medication needs, etc. Case by case basis.		
Case Load / Duration	100-150 cases, stratified High/Medium/Low. 1 to 3 months for low, 3 - 6 mos for medium, 6+ mos for high (could reach out daily for these). Transitions, too, make case loads vary.	Stratify cases 1 - 4 with 4 being imminent risk. Complex patient, could remain in case management up to a year or longer. 35 cases at Level 3 or 4; 160 at Level 2, 300 at Level 1; per quarter	70 - 120 cases right now, handled mostly thru phone contact. Also stratify. Piloting an in-home visit program with around 30 cases (the sickest members).	60 cases; in the process of stratifying for acuity (1-4). Trying to figure out how many level 4s a CM can handle (weighting). Medicaid members can be hard to reach. Care Mgt is different than Care Coordination at Select Health.	Connector Service will probably have between 60 - 100 cases, still determining the #. (likely to be 50 - 60)
Social Determinants addressed?	Questionnaire; outreach calls for health risk assessment; contract with Connect2Health	Assessment tools that have social determinant, disparity questions. Community	Determined during an initial assessment (usually).	Social determinants are addressed in the initial survey and ongoing surveys completed each time	

	who know a lot of resources.	connectors work to close gaps, disparities		a member is contacted	
Care Managers for all patients?	Any patient can request a Care Manager	Members can self refer, provider can refer. Transition of Care pgrm provides case mgt for inpatients. Usually identify members through utilization reports. Get real time alerts from ED registrations. Try to actually go to the ED to talk with those members. Also sometimes hard to contact the patients because of the "Payer" stigma. In-patient members go through Transition of Care and then into Case Management. Predictive modeling report (new): looks at other factors (not claims #s)	Form on the site, self-referral is fine.	Rely a lot on provider offices for referrals plus their metrics	
Have a Social worker? Help for	Yes, one SW for all the teams, including	10 social workers, substance use	LCSW is part of the case management	SelectHealth has an RN with a psych	

Utah Children's Care Coordination Network

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Primary Care Physician doing Beh Health?	Peds pop. Collaborate with Optum, Valley on shared Medicaid patients. Yes, clinician can get help, support, assess.	disorder counselors, ft psychiatrist medical director. SW and nursing for integrated case mgt for patients with both medical and beh health needs. Would like to work with clinicians, SW could even come to clinic. Psychiatrist could do peer-to-peer (Noel Gardner) with clinician, too.	staff; they all work in close quarters and communicate regularly. The LCSW will work closely with PCPs.	background, coordinates on all commercial and Medicaid. Calls monthly with county mental health. CMs will refer patients to primary care clinics that have beh health integrated when they see the need. Will also connect PCP with the county BH provider. Scott (Whittle) helps, too.	
Single case agreements when supplier options are limited?		Yes - called LOAs		Yes, single case agreements are done when needed.	
Can the clinics have a direct number/ name for payer care managers?	If care manager is on vacation, messages may not get to the person covering. Calls going through intake can be better managed.				
Can Payers send a list of high risk patients to the Primary Care clinic?	Difficult because things can change and HIPAA				

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Contacting Care Coordinators in clinics: call and ask for whomever does care coordination. Try calling, faxing and emailing. Also, can have the UCCCN shared directory (and contact Mindy)					
Medicare (Medicaid) Codes - lots of the layers of requirements have been reduced. Consent from the patient isn't as onerous. Update for 2017 - Written has been changed to documented verbal consent. Other major change, previously they had to have an introductory visit to explain CCM. Now if they have verbal consent and have been seen in the prior 12 months, no visit needed. See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf Commercial patients - be sure to get written consent before billing.					