Responses to Unanswered Questions from the CHCS Webinar

Establishing Accountable Physical/Behavioral Health Care Homes: Medicaid Innovations

October 27, 2009

Answers below are provided by CHCS as well as the webinar’s presenters:

- John Lovelace, President, UPMC for You, lovelacejg@upmc.edu
- Sandy Zebrowski, MD, Medical Director, Magellan Behavioral Health, SZebrowski@magellanhealth.com

For additional questions about the Pennsylvania Rethinking Care Program pilot projects, please feel free to contact either presenter as well as Fazlu Rahman, MD, Medical Director, Keystone Mercy Health Plan, fazlu.rahman@kmhp.com.

Stratification

1. Can you define “member stratification” that is being used? What are the criteria you are using to stratify the population?

S. Zebrowski: The initial risk stratification was based on the cost of behavioral health (BH) services in the 12-month baseline period. Anyone greater than or equal to 80% of the yearly cost was classified as high risk for BH. To stratify physical health risk, we used a DXCG score that looks at cost (utilization of service) as well as the risk inherent, for example, in combining multiple physical conditions with a behavioral health diagnosis.

2. Why is there a difference between the original high-risk assignment vs. the revised updated risk analysis? Sounds like you needed a new factor, i.e., “impactability”?

S. Zebrowski: Cost alone was thought to be a good place to begin for data mining. We found by looking into the clinical picture of individuals that the higher-cost members may not always require the highest degree of intervention with this program. They may already be getting the service they need, as one example. Impactability is one factor to consider as well as the stability of the individual within their current service.
Consumer Engagement

3. **How are you engaging members in the process?**

   **J. Lovelace:** The Southwest Pennsylvania pilot is using the following strategies to engage members:
   a. Letters to members;
   b. “Script” for customer service reps for outbound and inbound calls for the identified members;
   c. Outreach calls by a peer support and advocacy group;
   d. Outreach to behavioral health providers; and
   e. Outreach presentations through advocacy organizations.

   **S. Zebrowski:** Most members are being introduced to this program by someone that they know, e.g., case manager, therapist, or some other provider representative at the agency where they receive their care. The health plans also sent an introductory letter and fact sheet. Now that the project is underway, we find members engaging other members.

4. **What type of feedback did you receive from the consumer advisory group/consumer forum? What did they say that surprised you?**

   **J. Lovelace:** Consumers voiced concerns about privacy, i.e., they did not want their primary care provider (PCP) to know about behavioral health conditions; they also had concerns about the consumer’s active role in decision making. Yet, overall they had a very positive response to the pilot.

   **S. Zebrowski:** Some individuals were frightened about the prospect of sharing drug and alcohol and HIV information. We did not find much reluctance to share information between behavioral and physical health providers.

5. **Are the case managers contacting members while they are still in the hospital in order to facilitate engagement?**

   **CHCS:** For both pilots, case managers are reaching beneficiaries in the hospital setting to facilitate care transitions upon discharge.
Information Exchange

6. What changes did you have to make in your information systems? What additional software is used, and additional burden of data entry by providers?

J. Lovelace: We built a Sharepoint site to store integrated plans; both sets of care managers have access to specific plans on the site. Since providers don’t have anything extra to enter, data entry at the provider site is not an issue.

S. Zebrowski: Member data from existing systems is exported into a separate dashboard that is used internally for this project and exported to the physical health plan for member profile assembly. No new software was used. Providers thus far are not responsible for data entry.

7. Did you use an existing system, home grown, or state developed?

CHCS: Both pilots are initially using a combination of home-grown systems. Based on the experiences of the pilots in sharing information, the pilot partners may consider investing in new systems in the future. For the Southwest pilot, the Sharepoint site is home grown; the care management systems that feed it are also home grown in the case of the physical health system, and proprietary (Askesis Development Group) in the case of the behavioral health system.

8. Please describe the data management and information exchange. How is the information shared among providers and is it also accessible or reported to the Medicaid program?

J. Lovelace: Data is shared between the two Medicaid payors (physical and behavioral) via a Sharepoint site. Information is shared with providers in several ways – in some large practices, we have on site nurse care managers, who have direct access to our data; in others, there are “virtual” care managers to relate singly to the practices and share patient-specific information.

S. Zebrowski: Currently member profiles are shared with providers by mailing hard copies. Providers and navigators are encouraged to contact plan-based case managers with any new inquiries or questions. An upcoming enhancement will allow providers to access the information through the web. All data is accessible to the state Medicaid program.

9. How do you ensure an integrated /complete care plan with multiple providers/payers?

CHCS: Both pilots are attempting to get as much input as possible from relevant providers, including PCPs, therapists, case managers, etc., but recognize that not all members will have a completely integrated plan.
10. Where or how is the member profile stored? Can you share the profile materials?

**CHCS:** A sample member profile for the Southeast Pennsylvania pilot and integrated care plan for the Southwest Pennsylvania pilot are available at, www.chcs.org/usr_doc/Integrated_Care_Plan_Template.pdf.

**J. Lovelace:** The member profile is stored on a Sharepoint site that we coordinate.

**S. Zebrowski:** The member profile is stored electronically at Keystone Mercy Health Plan. Magellan has full access.

**Provider/Navigator**

11. How many providers are involved in each of the pilots?

**J. Lovelace:** The Southwest pilot is working with seven large primary care provider practices, four community health sites, and several individual practitioners as identified by working with members. Behavioral health provider agencies are also involved and there are eight organizations that see the bulk of members on the behavioral health side.

**S. Zebrowski:** Each of the three counties identified core behavioral health provider agencies to participate. Corresponding primary care provider practices that serve a high volume of members were also identified.

12. What are the credentials of the various navigators?

**J. Lovelace:** The navigators in the Southwest project are chosen by the members – we have no specific requirements for navigators. They could certainly be case managers or peer support specialists who are certified, but that is not a requirement.

**Coordination of Physical/Behavioral Health Needs**

13. What are some of the specific challenges in coordination between the mental health and physical health organizations — how are these two organizations collaborating?

**J. Lovelace:** Confidentiality requirements are the largest legal hurdle. Data exchange technical issues have arisen, but have been addressed. Coordinating with services outside the health arena and knowing what they are (housing, for example) is a challenge.

**S. Zebrowski:** Prior to this project, BH providers were encouraged to communicate with the PCP at least one time in every episode of care. PCP communication (consent) was required in every behavioral health record. Most often the consent forms were presented on audit, but it was harder to document what meaningful communication may have occurred. The main barriers
seem to be consent, time, and the sense that the communication would have a direct impact on patient care.

14. Do mental health and substance use case managers need more knowledge, skills, and abilities in recognizing physical health care issues? Conversely, do physical health care coordinators have enough information on how to work with and communicate with people with severe mental health issues?

J. Lovelace: Yes, absolutely; care managers on both sides could benefit from broader understanding. We address this in forming an integrated case management team and having integrated case review and supervision. Physicians with specialization in both areas are routinely involved in supervisory and consulting roles. For physical health case managers, a major challenge is understanding the resources to address needs, and interactive physical/behavioral health issues (e.g., managing diabetes for a person with schizophrenia).

S. Zebrowski: Most have sufficient background knowledge. We hope that the training and experience offered by this project will enhance their skills.

Financing

15. Are partner dollars at risk?

J. Lovelace: Both the PH and BH plans already held risk contracts under the state’s existing HealthChoices managed care program. For the pilot, the state has created a “shared savings” pool that would provide a potential payment to each entity if the project goals are reached.

S. Zebrowski: Health plan partners are already in an at-risk contract under the state’s existing HealthChoices managed care program. This project has been associated with an increase in resource expenditures for the plans and providers.

16. Do you have problems with the “same day” billing issue in which providers are prohibited from billing for more than one medical service on the same day?

J. Lovelace: No; we allow this on both sides; we do not allow billing for the same service by the same provider on the same day, but that does not seem to pose an obstacle.

S. Zebrowski: This depends on the services. Many services can be billed on the same day.