Wednesday Thought Leader Discussion

February 12, 2025 | 9:45 am ET

Note: *The following text was transcribed using an automated service. Any misspellings and typos are a result of the service as the transcription has not been reviewed.*

Speaker 1 0:00

Because you get to stump the panelists. There's there's nothing you can't ask within reason at doing that. But I'm going to start, I'm going to start off, and then turn to all of you. So I was surprised in North Carolina, they are one of the first states that actually has a fee for service schedule for social services. But I was surprised at how few social service CBOs are participating. And Cindy, you were telling kind of a personal story about this, no, but I think it's an interesting thing to share, because if we're going to build capacity, you know, in doing expanding that lens of healthcare to include more social supports, this capacity issue is a big one.

Unknown Speaker 0:41

Yeah, please. Yeah. I thought it was interesting. I

Speaker 2 0:43

was sharing with Monica in between the sessions that so my mom, for example, she serves they have a soup kitchen at her church. She's very active in the church and and what she does is goes on Wednesdays, is their day in the community to serve the soup right to the folks that might need that as a resource. But my mom is 75 years old, and she is not a person that is literate with computers, right? Because she didn't grow. She's not a digital native at all. In fact, my sister is her IT person. Some of you probably have that role in your family and and so my mom is interested in feeding people. That's why she goes to the church and does all the stuff to get the food out to have have that day every week. But what she is not interested in is going on a computer and and entering any kind of a claim or number or any of that sort of thing. Because she's not again, not, you know. So somebody asked her to do that, she's going to say, No, we, we don't do that. And so training that workforce, so getting people motivated to do that so they can keep giving the soup to people, is a really different sort of level of inter in our interaction and engagement with with because most of the people that are doing that are doing it as a heart mission, right? They're doing it because they believe in it, but they're not necessarily wanting to learn how to do all these other things that now make that a job. And that's the way my mom looks at it. She's like, I serve the

suit because I go to church and that's what I believe I should do meanwhile it she did human resources for years and retired from that. The last thing she wants to do is anything that represents a job for her, right? And so that her church is not involved in this, even though they knew about it, and she's in a county that has got a lot of deficits, but she's like, we're gonna just keep serving the soup, because the church is who the people of the church bring this stuff there to make it right? They are not dependent today on any other system, and they don't want to be either, right? So it's a really different dynamic. But they're still feeding people, but they're not, they're not being captured in the in the cost equation at all.

Speaker 1 2:55

That's interesting. Yeah, it's it explains the cultural gap, because Yvonne, when you said there were only 160 organizations actually participating in getting paid for this. So I was surprised. Other questions,

Unknown Speaker 3:11

no questions, you've answered. All the questions.

Speaker 3 3:20

Statement around s do better now for six years. And I want to compliment, you know, Cindy and Humana and Yvonne as well. This is, this is, and I've spoken to mama. This is the hit. This is the main I'm gonna do this about three seconds. But this is not for the faint of heart. I want to say it again, sound for the faint of heart and mind. Asked a question earlier. Where's the entrepreneur spirit? About going by doing this one, you're going to need a very entrepreneurial spirit to do this. So help person care. We started in March 7 and eighth of 2019 2018 at this process, and we were doing things way up front of the state. Went on and did it because that's our business strategy. But the providers we work with, infrastructure is a major issue with technology. It's kind of what Cindy just said about her mother, but not to that. You know, to some degree providers, because you got to remember one thing about this little thing, and I'm so excited Monica, I'm gonna talk about this up today, because this is a major revenue gainer. You really do understand that now. You're not gonna feel good about going into you can do a lot of honey, kiss and cousin kind of approach, and you're going to say, your boss gonna say, Where's revenue, where's money, but it gets there. And this is our whole business strategy infrastructure. You're going to have to scale and prune your personnel to get there, the people to side with you. Then 1215, whatever time frame it is, love them, hug them, but they may not make their journey going to the next phase these lessons we've learned in six years. The other thing is that you got to make sure that again, infrastructure, technology is another one. So all things that they're talking about doing here today, I'm not trying to, you know, hug and Monica and everybody on the stage, but I'm telling you. What is real and what's going to be taking place from that perspective. So, and you got to make sure your staff is tuned to it as well. So things that Yvonne mentioned earlier about, you know, she was very tactful about getting the people there, getting them their providers, they're there. It's a lift. But I would tell you, from my perspective, going into seven years, and what North Carolina is doing, of being, you know, kind of a poster child. It's a lonely world, because taking the whole person, Esther, which again, with and you go to our website, you know, we kind of share with everybody what s do, its really is. So I just want to give a couple six years experience on things and doing it. From my perspective, there is a good financial side of it as well. But don't look at numbers immediately. The KPIs, they will take a while to get there, but if your heart and your

commitment, and you know about Kaizen, the approach to your business model, then you will get there. But don't look for immediate return that first year, 15 months. That's not going to happen. Just a couple of comments I want to share with the group,

Speaker 4 6:02

Elena. All right. Am I okay? There we go. All right, so I just wanted to say that anyway. I've been waiting to say it all morning anyway. So thank you for that, Jerome, but I wanted to sort of talk about what Cindy said as well. I don't want us to disparage the community based organizations or think ill of them. There's a place for the church to remain where they are un, non inverse or unimportant, unreimbursed or pay for their services, just like, you know, aa, that model, right? You know, staying true to that there's a place for them in the community. Also, I look at schools, I can't get schools to bill Medicaid for services that they render. You know, it is hard. You know, they're providing services psychologists, social workers, psychiatrists, and they will not bill Medicaid, you know. So this is going to it doesn't happen overnight. It takes a while. So what I would say is, because of the the administrative burden, just, you know, the aversion to it, another option that we've been using at the state and I really feel strongly about is philanthropy. Partner with philanthropy. They really show up, particularly in the SDOH space. They're there. They're the ones who have been there. We would not be where we are now with SDOH, without philanthropy, you know, in North Carolina, we got Blue Cross, Blue Shield. We have the Duke Endowment, you know, dogwood, you know, just lots. So I'm sure it's you know, the same others, but I would definitely connect with them as well.

Speaker 5 7:53

So in California for Medicaid, we have an ECM program enhanced care management as a benefit under Medicaid. And I'm curious Many organizations have gone about having to evaluate the network lead entities. And I'm curious how you've determined who's going to be your network lead entity, and how are you measuring their effectiveness? A

Speaker 4 8:24

and a RFP process, right? There was a process, a formal, competitive process. I was not a part of that process, but that's what they did. And the criteria actually was very minimal, you know, in terms of the criteria to apply, to be considered to apply. So and we're measuring them. We are evaluating them as part of the full evaluation process. So are they doing their responsibilities, what they've been tasked with contractually? Because, again, there's a contract with them. Are they meeting those contractual obligations with the meeting the need, and we're looking at that regularly, I will say, the more we can get real time data, the better. That's been a little bit of a challenge. Is the real time, near real time, I think, will help us with that. But so far

Unknown Speaker 9:23

so good.

Speaker 2 9:26

One, one thing I would add to that is so actually serve on a sub board of one of those lead agencies, and the department required them to have certain types of members on their governance structure. And so health plans like ours, and there's a standard plan member and a tailor plan member on this board. And so as as a board member, I'll just put that hat on for one second, we are constantly receiving dashboarding from the lead agency about everything from how many food boxes got delivered and. Cost of care, and so in this, in the way that they structured this, and I think this is a really key thing, they started it with metrics, instead of waiting till later, right to let's see what we can measure. Now, they started it from the very beginning with dashboarding and metrics and KPIs, so that as it grew, you could see that trend up and and as it has now stabilized, but, but everything from counting the number of providers, which is why Yvonne has such risk, rich data is, everything is, is really measured in this entire program. So just to add that,

Speaker 6 10:38

Hi, sorry about that. Julie short, all from Minnesota, I lead children's and family service organization. We about 44% of our revenue is Medicaid, but 26% is commercial insurance. And in Minnesota, our children's therapeutic support services code does cover some social determinants of health. There, there, they've actually done a pretty good job. What, where we're finding and we have philanthropy. I love your statement about philanthropy. About 10% of our budgets philanthropy, we couldn't serve the underserved without it. That said, commercial insurance does not keep pace with it. And I've got some conversations with a couple big commercial plans right now, and they want us to enter into a value based contract, and we're saying, at least pay what you should pay first, and then we'll we'll have a conversation. I mean interpreter. I mean it's not even just the some of the more progressive ideas that you have, like food and but you know, interpreters and transportation, and though our state has us. Has a system for paying for it, the commercial insurance payers are not following suit. What advice do you have for us around that

Speaker 7 11:54

commercial being an employer group, right? Like employer, employer individuals? Yeah. So, perhaps not coincidentally, Humana no longer has employer or individual insurance. I was there when we did. And you know, I will the challenge for the payer is that the employers that we have, we have to re contract with every year will change plans if they can save one cent so there is no margin, and It what Humana, frankly, was incredibly not good at it in the most recent years, because of our emphasis on whole person care in trying to do this, and we couldn't get the employers to come along with us on that journey of the benefits of that. Couldn't get permission to like, collect social needs data, or share that data or expand and have more creative benefits. So I don't know that I have a good answer for you, other than

Unknown Speaker 13:13

it's a poor delivery

Speaker 7 13:16

system probably for the type of care that we want to see, and

Speaker 6 13:19

I can build on that a little bit. I worked for a carve out behavioral health plan for about 10 years, and part of the other problem is that, as she was saying that an employer is going to change plan every year, every year, the insurer doesn't have an incentive for those bigger, broader health outcomes that somebody might be having be on Medicaid, perhaps their whole family for the whole lifetime, in many cases. So there is a more of an incentive, short 10 year. Yeah, there's more of an incentive of getting those like slower, long term outcomes for the for the commercial payers. Unfortunately, good point you need to

Speaker 1 14:02

go in with your own fully loaded cost model and then and go, at what point are you just going to walk away? Yeah, you may take the shave on the margin or something and say, Well, you know, in the back of your head, here's our negotiating platform. Here's what we're asking for. Here's the bottom line of what we'll pay. And just be prepared for the be

Speaker 8 14:28

prepared. So So we've seen some recent innovation from grocery stores in kind of providing food as medicine and serving as a provider. Some of the issues that they see is really around managing the encounters. But have you seen any innovation in your markets around that? And do you see that kind of the market moving in that direction where they start to not replace but complement food banks? Yes, yep. They are definitely partner. About

Speaker 4 15:01

that. And I actually, I think that they were there before they've been there, at least that that I know they've been in that space and working with food banks, obviously part of the community, also, I've seen some, some innovation in technology around, you know, AI and trying to access services. How do you get people to know what community based services are around? And a lot of that is coming. I'll just share a particular example. Somebody approached me. They wanted to create a an app for grocery stores, a particular grocery store chain because their employees, quite frankly, might be Medicaid recipients, right because of the low compensation, so they are concerned for various reasons, from even an insurer perspective, you know, if they have a Plan, that's another you know, market for you, you might want to consider what they if they have their insurance and the people that they're carrying. So just interesting that you mentioned, grocery

Speaker 1 16:11

stores are getting into kind of the prescription deal, kind of initiatives. There's a lot, and I can say, I know, I got some research on this. There's a lot now, of evidence based models for people with diabetes. These

are meals designed for people with kidney disease. And the groceries are getting more active and getting reimbursed for health plans,

Unknown Speaker 16:33

for putting together

Speaker 8 16:34

those packages. And then, from what we've seen, is that the reimbursement is probably the biggest roadblock in terms of what they're trying to figure out right now,

Unknown Speaker 16:44

exactly.

Speaker 8 16:48

So that's that I didn't know if there was, if you've seen any kind of innovation in that space where people have if there's, if there's a platform, or if it's going through the state, right? Because what we've seen is that, you know that any given grocery store may have seven, 810, health plans, representative in that market, right?

Speaker 9 17:18

Do you have any advice on if you bring a product to market in any particular state that may have four or five different MCOs, and you're faced with the paneling is, you know, you got to get paneled with all of them. So that's not the big issue, but that they might every plan might have some it's the same product we're marketing to each plan, but each plan may have a different rule about what you bill when you bill it, you know, those kinds of things. And it really is discouraging when you have one product that five different MCOs are interpreting in slightly different way and paying anyway. Is there any way to, I, you know, I don't want to. It's not making them collude, or that kind of thing, but you know how to, how to shape those programs and payment models, and mostly we're into value based payments that so that it's reasonable to continue to operate in that market is not going to

Speaker 4 18:30

require that, you know, and so that that is the end. And I, and it hasn't happened by, you know, they have not done that. But I, and I honestly, you know, we we've thought about it, we've tried different variations of it, you know, along the way, and we still get back to this and but I do think that they're all cognizant of the administrative burden. And I don't know, Cindy, what are your What are your thoughts there? Yeah, I'm

Speaker 2 18:59

going to go back to something Stephanie said earlier about, you know, doing something very local and unique is is really hard. And even though we're a local and unique plan in North Carolina, only over this, you know, sort of half of the state that we have when, when a provider brings something that is so really unique, we have to design a whole system around it that is as hard for us as it is for her as a huge plan as Humana, because every provider is not doing the thing number one, or every provider that is doing the thing is not doing the thing the same way. And so as providers, ask us, Why don't y'all get standardized this word I hate. I wish I could get rid of the word standardization. In my life, every provider in North Carolina wants us all to do it the same way, yet none of them do it the same way. And when you flip the script back and say, How about y'all go figure out how to get standardized and then ask us to standardize our process after you have standardized yours. Yes, that's when that conversation ends, because they have no intention of standardizing each their product, whatever it is, against all the other competitors in the field, right? Because everybody's got their edge and and so for us, I will say, throughout my whole career, Standardization has been an issue, a topic, but but it, we really have to wear all the hats and look at it from every angle, because it, it is hard to do in any system, because everybody's on a different system, all those things. So I don't know. Stephanie, you want to say

Unknown Speaker 20:34

something? Totally agree.

Speaker 7 20:38

I think the one, I don't know if this is advice, and don't to my boss that I said this, but even the report, even the record, even the reporting is in the Billings, payments and structures, negotiable.

Unknown Speaker 20:53

You, if we need you,

Speaker 7 20:57

you know, negotiate with us. Recommend, tell us what is your standard package and the the terms say this is how we function the most with the least administrative burden, and charge us extra if we want to something different or ask for something extra. You know that's not going to work every time, but I think we're learning we don't know the best way. We are mostly applying, like contracting with a specialty provider, like model on to you guys. So we don't actually know what works best, because most of us haven't worked where you are, or have attorneys and all those folks who know how to do that, necessarily so tell us what is the most efficient, cost, efficient way to do it and negotiate? I would

Speaker 1 21:53

say the challenge Barbara. There's 4000 health plans and 600 ACOs

Unknown Speaker 21:58

and probably 10,000 employer plans with

Speaker 1 22:01

their own rules. I found the only way to sort of break order in chaos is with your information platform, both up front, making sure whatever the payer is we're gathering the right info to get approval, and then having some kind of revenue cycle management software on the back end that can adjust to the payer. The other thing I will say is this is just a piece of advice for anyone of the provider organization. Sometimes you can improve your margins a lot by canceling the lecture contracts. If you have a lot of low volume contracts, sometimes the administrative burden of just maintaining the contract is more than the margin you're making on the services if you're providing very few services. So some of it is too just focused. How do we build market share and referrals from the plans that pay us what we think is a bear great and are giving us volume, and try to increase that volume and we'll literally cancel electric contracts

Speaker 7 23:04

with mobile and bonus points if you have data about how much administrative waste goes into the what the reporting, because we also really hate waste. And

Speaker 2 23:13

yeah, the thing I would add to that is, I think so first of all, from what Stephanie said, very few providers in the behavioral health space ever negotiate a contract? They sign whatever we send them done. They don't redline it. They don't ask for administrative relief. They don't they don't do that. I mean, we have very little of that going on in North Carolina right now. I'm glad I don't see too many North Carolina faces in the room. But I agree, if it, when providers do negotiate it, they always, usually get something that they wanted out of the deal right. And so it's important to think in that sort of business oriented way, and especially it's not always money. Sometimes it's that administrative burden, and for providers that can prove good quality and those kinds of things, sometimes we're more than happy to reduce that administrative burden, because often it's on both sides of that right. It's on your side and our side and and so I would just add that to the equation. Also agree 100% on if you're doing a special thing and it benefits us, we're likely going to come to the table on rates in terms of giving more money for that special thing that you do. We do that in a sort of pay for equity way in our rural counties, where we have a higher rate structure to for providers to serve those areas, because it's going to be lower volume that we need the people served. So I would just add that, and I couldn't agree more with Monica on looking at your payer mix, because that is probably where you're losing a lot of money you don't even realize.

Speaker 6 24:47

I'll add on that with what's going on in California. That's been very complicated for provider organizations that might be across county lines, that might be dealing with one to 10 i. Managed care plans, and really finding that sweet spot of maybe you don't need to go with all 10 of them, maybe you have enough of the patient population in one of them, or two of them, and they are better to work with. And perhaps the all of the plans you might be serving two people on one plan and 20 people on another plan. Do you want the admin burden for the two people,

Speaker 2 25:22

and if they're not focused on quality, the same way your mission drives you, Why would, why do business there when there's, you know, I like the you know, not to, not to try to make it look like collusion. But I would love it if a provider said, you know, we're going to drop these other plans because we want to serve your population and be your niche provider and and now I get better access, I'm going to be very motivated to pay good rates for better access, because I'm not competing with the other seven or eight plans in the state for the access to those few clinicians. Yeah,

Speaker 7 25:54

look at those caps measures I want. I want my patients to my members, to get the care they need when they need it, and if you can help with that, then that's amazing. How are you defining good

Speaker 2 26:07

access? So the state has some things in our contract around that when the seven day follow up, right? He does, right? So some of it's the HEDIS measures. We have a in the LM, EDM, co world of North Carolina. We have these defined urgent, emergent and routine sort of appointments for any patient, regardless of what is going on, and being able to hit those metrics is also important. So somebody that's in emergent, it's like within two hours, and somebody that's urgent is within 48 and then routine is set one to seven days. All of that tracks tortillas, but the metric on the plan is, did we get them an appointment? Were they seen, and was something billed for that encounter, and in that, in that, or however we triaged the person. And so it's very important for us to get that rapid access. But one thing we found out is we had been paying for that. So we in North Carolina, we have our tailored plan product. We have a Medicaid direct product, which includes dual eligibles, so that's a little bit of a black hole for data, because it includes Medicare, which we don't get well. And then, and then we have the state plan for indigent care people that have no insurance or under insured and and we were, we were funding this rapid access. And 2021, when the standard plans took half the Medicaid population away from us, or more, we were still funding that rapid access for them, and providers didn't give us any preferential treatment. So we just recently eliminated all of the access funding, because even though we were paying for it, everybody was getting it because providers didn't grow with the shift in plans, and because our members remember finding needles in a haystack, it's really hard for a provider to structure around our population as the primary walking in the door.

Speaker 10 28:10

Well, thank you all for your candor. Today, I always enjoy these opportunities to hear folks from the payer side talk about, you know, their perspective and pain points, and on the provider side, maybe what we can do to help. And so in full disclosure, I'm a provider in Kentucky. We've had a long history with Humana and all the products you have, and used to have, including employer side. We used to get our employer health insurance from you all back in the day too. So me too. Yeah, right. So I work for community mental health center. We're based in Bowling Green. Have operations across 18 counties in south central and western Kentucky, predominantly rural and urban. Actually, I'm sorry, rural and

suburban, not urban. Actually looked at the data the state put out Monday of this week on the Medicaid population by payer across counties, and so outside of the Louisville Lexington areas in Kentucky, we've got the largest amount of your members in the Medicaid program in our catchment area. And I'm impressed to see the data that you guys talked about with your value based care report, in the penetration rate you had with those types of contracts with your Medicaid market in Kentucky. But as a provider like we don't see any of it like absolutely zero. It is solely driven by primary care, and they really don't want to see the patients that we see. And I don't mean that to be critical to those providers. I think most of them in Kentucky probably limit their Medicaid volume, and of that especially limit those perhaps with SMI that are really the folks that we support. So we have struggled for years to try to make this transition in practice and operation reality, to value based care because of these kinds of arrangements. Not with you, but I've had conversations with humans. As you know, we already have BBC with primary care providers there, and that's really where the. Conversation ends. So from my perspective, what can I do? How do we get to be a player in this game?

Unknown Speaker 30:07

Oh, my goodness. Well, if I could ask a related

Speaker 1 30:12

question of the I read the Humana 11th report this morning. Everyone

Speaker 7 30:21

needs good can I say we started at 815 you don't Okay? My question is,

Speaker 1 30:26

I saw there were, like, 70% of the Medicaid lives that you have in Kentucky are in BBC? Does that exclude people with SMI and SED?

Unknown Speaker 30:38

Do you know, and is there an opportunity for like a behavioral

Speaker 1 30:42

health provider like Joe mans group life skills, to add primary care contracts with the Kentucky Medicaid, with

Speaker 7 30:53

humans Medicaid, so we can talk later. I don't know who you've spoken to at and the Kentucky healthy horizons Humana healthy horizons plan, we are exploring how to do value based care in behavioral

health and other specialties, really trying to again align incentives across different types of providers, but it's definitely a work in progress. So, I mean, again, I would say I know that you've spoken to people at Humana, probably want to, you know, like, make sure that we were talking to the right ones to try to solve that, because we have a intense interest in expanding. We're we're getting more members. State recently grant. I don't know there was an appeal. It's a long story. Anyway, we're going to get more members in Kentucky. We want to stay in Kentucky, but this is like a tough nut to crack for them. So I think it's one of those things that is like, we really need good ideas that are sustainable under the current model. But I think we have all agreed that, like we push really hard primary care, value based care, we believe in that. However, to your point, there are other types of providers, types of patients, that are not they're being left out from there. And I think we just, we acknowledge that, and we're, we're still learning how to do that part. The

Unknown Speaker 32:27

comment you made in the opening session about the challenge

Speaker 10 32:33

of trying small projects and taking on small risks and the structure that is compatible with how to operate. How do we get to what you how do we solve the problem you just said, if we can't do that, it seems like if I came to you as a solution, but it's specific to my population, because I'm different than Louisville, Lexington, Northern Kentucky, or say, Appalachia, Eastern Kentucky, from what I've heard from others in your chair and other payers like, we can't do that because it's not scalable, big enough, etc, but that's how we solve the problem. And so maybe it's me being on the provider side, another payer side, like, I don't know how we ever cross that bridge if we can't get some give from the payer side to trial. Like, some of the problems we've approached like, it was 100% of loss. It's like a, not even a rounding error for the financial impact from the payer side. But we can't even get traction to try and so some of that, it's like, I don't know how to I don't know how to problem solve with you as a partner. If that's the game, the rules of the game you have to play by

Speaker 2 33:42

it's so let me speak to just that. I realize your situation in Kentucky is is unique to Kentucky, right? Maybe being a specialty plan for that population, which is the direction North Carolina chose to go, right, to have these tailored plans that are specific about that. So in the last six months, we've we've initiated a $12 million investment to create rural behavioral health clinics that do exactly what you're it's a it's a primary care it's a behavioral health model with primary care integrated into it, right? And some other things, like all the peer support and other services in a continuum for mental health and substance use population. And that model is very unique to our plan, but it gets the same solution you're talking about, really. And I think some of that goes back to that policy question, the general assemblies, legislative kind of things that Monica talked about in the in the morning session, yeah, yeah,

Speaker 7 34:44

I was that was going to be my my answer is like, unfortunately, in Kentucky, the system is not, we are not accountable to the state of Kentucky for the outcomes for this, this population. Conversation that might matter, that would incentivize us all to go and rush to partner. So we're highly receptive to being told and hell, you know, we have quality withholds. We have quality all these reporting requirements and improvement plans with the state.

Unknown Speaker 35:18

Sometimes we have to be told first,

Speaker 2 35:22

yeah, whereas we are very motivated to make our communities happy and maintain a public system for the behavioral health and IDD populations, so everything about us for the next bid cycle is about maintaining a public system for this group of people. Maybe

Speaker 7 35:39

it's a maybe it's an argument to the legislature that you don't have, we don't have a stand alone type of Medicaid plan for this population. Maybe there's a better model,

Speaker 2 35:50

and the cost of care is probably a lot higher because you don't which would be the evidence you would need to make that argument.

Speaker 11 36:02

Do? Hi. Good morning. Going way out of my comfort zone, guys. I'm fairly new to this field, in general, the industry of healthcare, but I'm coming more from the technology side, from an EHR perspective, and I'm hearing some new terms that I've never heard. I know there's a mix of providers, payers, you know, a lot of people in this room, so I'm just curious, from a EHR kind of technology side, is there anything that we can do and we can offer Data Wise that would allow providers and other folks to, you know, show data and say, Hey, we have data from this population that we're not already doing that would allow a transition more from like the fee for service to value based care.

Unknown Speaker 36:49

Who did you say? Which EHR you with? I'm

Speaker 11 36:50

with qualifax. So right now, I'm currently working on NSYNC. But credible and care logic are also two of our others, and I know credible, they focus primarily more on behavioral health

Unknown Speaker 37:07

data exchange at The federal

Unknown Speaker 37:19

level and interoperability just doesn't work. I

Speaker 1 37:23

mean, and the I think, for any specialty provider that wants to, because I do think that for specialty providers that want value based Congress with health plans, they're going to have to add primary care, or CO locate the primary care, integrate, what are the model, but be able to go to a Humana with a cap rate proposal that has primary care and behavioral health. The challenge is the interoperability. If you don't own it and they're not part of your system, then getting the data that you need to actually manage a cap rate, risk based cap rate contract is difficult. I mean, I don't know if you'd agree

Speaker 2 38:01

with that Sydney, but absolutely. I mean that providers have a hard time showing any, any outcome data, any any of that is it's hard regardless of what, what platform they may be on, and there's

Speaker 1 38:14

not a lot of it. And I will say to that person, company excluded, there's also not a lot of ability for there are not a lot of Payers willing to actually do bi directional data with providers. And I would say that that is, I don't

Unknown Speaker 38:32

know we try so hard. Please take our data ability

Speaker 1 38:37

problem, a policy problem, a competitive advantage problem. I'm not quite sure what the problem is. Me, interoperability is

Unknown Speaker 38:46

the biggest single slumbering block for

Speaker 1 38:49

strategic development, for really consumers with a lot of product division, because they're not well served by a kind of universal health care

Speaker 7 38:57

system. That's right, I will say we have to be. We invest so much time and money into interoperability. It is, there's so so many teams, so much it spend committed to to that. For example, I said we share back social needs, screening data. The use case is the epic payer platform, and which is great. We share a minimum amount of data because we have to have the same data standards from our side through epic to whichever version that the provider has. We have to standardize terminology across it has to have a place to go. It in all of that, we started that project that like officially went live with just the social needs data part in the second half of last year, we had been working on the data governance and data flows for. Like, a year and a half, two years. So it's, it's our commitment that we want to do it, that we think it's the right thing. We're trying to empower providers. But it's still a handful of health systems that actually opt in to that platform and turn on that function. And so it's, it's, it's, yeah, it. We're, we're committed to it. We're putting money into it because we think it's the only way. But it is an arduous process. Is this? I hate to

Speaker 1 40:30

ask this, and I know this is being recorded, but is this an epic

Unknown Speaker 40:36

problem? No, so it's not an ethic.

Unknown Speaker 40:39

It's not the Epic's unwillingness to

Speaker 7 40:43

share data. Oh no, no, no, no, I think that we've been we've had really long standing really good partnership with Epic.

Speaker 12 40:58

Thank you. Good morning. Mary gay Abbott Young from New Jersey, yeah, gee,

Unknown Speaker 41:07

you're a brave woman.

Speaker 12 41:10

On or about July, 1 of this year, for the first time in history of our state, Medicaid will begin to play for social determinants of health. They have taken the road of case management, where you have our protocols out for our MCOs, the providers are still waiting to hear. Here's my dilemma. I represent primarily the shelter outreach, those who have dealt with homelessness, and I hear you about charity and philanthropy if you want to start in something new, and then if go get some private dollars you want to pay for your services, get some Medicaid dollars. That's kind of the risk we're in. So we have this industry that has depended on years and years of goodwill community some big time. You know, a couple of couple corporations are very generous to us, but that is a world that is dying. And so this whole if I'm going to call it, the emergency services system has to respond to this change. They're the poorest cousin at the table. They're the least equipped to make the change. And here's the rub, they touch. 70% of the patients that Medicaid is targeting. We meet with the monthly we explain this over and over and over, and as we are doing so, we're trying to bring our members along into the modern world with things like an EHR biggest problem we ran into, it was a disaster. It's an absolute disaster. Our members can't get up to speed because they don't have the resources, even though we had Readiness Grants available, but yet, they are the ones who have the direct contact with the population. We've tried to get Medicaid to look at if someone comes into one of our units shelter or our outreach fans, and we notify the case management team, somebody has to pay for that to happen.

Unknown Speaker 43:01

They don't think that that's the case,

Speaker 12 43:05

and so we deal with 70% of the homeless. We're going to be the funnel, catching everybody and passing them out, because we can't get into the game. So just be very interested in your comments on that. Thank you so much. There's a

Speaker 1 43:22

reason, there's a great study up that said, what's the uncompensated cost of whole person care? And the model the I like the article because I'm a staff geek, and I don't know if the assumptions are right, but I like the model. Their calculation was that it was to do whole person care cost the average practice, $99 per member per month in uncompensated services. And that would be things like the, you know, the warm handoffs and, you know, emergency room interventions and crisis conceiving and all those things. And I don't know, unfortunately, until you move to a more robust capitated model, sort of what Humana has done with their VDC project. You know, you're going to continue to be in the position where all of these coordination services are going to be expected to

Speaker 13 44:15

happen, for happen. I don't know how else to say it, because there, unless you when you say, and I have to believe

Speaker 1 44:33

that they would need to change the state plan amendment and actually put in a code that was to pay for The care coordination and our transition so you could fill in that unit. But we've had the same problem with injectable medications, getting a payment rate for someone to do the injection. I could go through the laundry list of uncompensated coordination services

Speaker 6 44:57

that are just California did put in place when they were. Am putting through Cal aim of an incentive for the outreach and engagement, and even some counties went so far as adding an additional incentive payment for people making referrals. So using find help a lot of the time, they can track those referrals being made. And it's not a big payment. It's like five, $15 something like that, but it's ensuring that the referrals are being made. Yeah, over and over and over, you're getting the referral incentive for the through the health plan. And that's from Inland Empire Health Plan is doing that Inland Empire in California, I EHP is how it goes by.

Speaker 14 45:45

In the same vein, our company, course innovations, is doing something very similar to what Find Help is doing, in the sense that not only is it around capturing those referrals and being able to track those and report those, but also all the encounters in between. And so we've really focused on develop the encounters in between. So how do you track all of these encounters along the way? We've actually developed technology for the outreach programs so that they are tracking each of their encounters along the way as they're doing recruitments, so you have the full robust collection of data along the way to show what it takes to get somebody through the door, so you can tell the story later. That's the key is. How do you do it on the front end, so that you're able to holistically tell the story and convince somebody who you need to convince.

Speaker 12 46:33

I'm usually pretty black. We find out that in our membership, the majority of our organizations could not make two payrolls. So when someone says, take on this additional expense, imagine these people have got a 50 bed shelter, and somebody's saying to them, capture all this and come back to us in a year or two, we'll see what we can do. That's really I mean, I'm not trying to be argumentative, but I'm trying to say these decisions have been made. The plan is ready to go and they forgot the primary bus driver, what you'd be looking for. Anything that is capturing that data

Speaker 14 47:08

is something that's also helping you get your job along the way. So you've got to make sure that whatever tool you're bringing in isn't just capturing data, but it's actually facilitating the work and streamlining whatever work that needs to be done in that given day. And it's all being wrapped up into something that can be easily reported so you don't have more you got less recommendation

Speaker 1 47:28

to Julie about their health plan. The other thing is just to tell them you're going out of business.

Unknown Speaker 47:35

I mean, I will tell you my favorite nuns for whatever reason

Speaker 1 47:41

that's good or bad. But my sister Mary Margaret, they ran a home for mentally ill girls who were pregnant or it was a very complicated population, and she felt they were the lowest paid provider in their particular state for that service, and they had the highest acuity patients. And we tried everything. We wrote letters, we met with legislators. In the end, she did the thing I couldn't do. She put all the girls in two busses and drove them to the capitol and went in and said, If I don't get a raise, I'm leaving them here, and we are closing. And as she had to do, she had to get the order to agree to that. I mean, but they made the decision it was not feasible to operate going forward. And that got attention, and that got an increase in pay. I mean, I'm just saying sometimes what you're looking at is truly fiscally rumors. I mean, sometimes that's, going out of business, and deciding to do that is the only way to get the system, whether it's the state or the health plans or the county, to actually say, what would we do if they're not there? Thank

Speaker 12 48:52

you so much for that suggestion. If the shelter don't get on board with this initial project,

Unknown Speaker 49:01

yeah, you're being recorded and broadcast

Speaker 12 49:03

live. There you go. If the shelters don't get on board with this initial first step in the Medicaid two years from now, it's going to be even further down the road. So that's my concern, and I think this may be the time to play the card. I think that's a great whatever. That's going to be, brothers going to be, brothers going to be, you know, all the shelters are going to go on strike. And, you know, by the way, it's Code Blue, all that nonsense. But the question is, how far are you willing to go to win the battle? And that's really an excellent question. Really good, I

Speaker 1 49:33

will say. And then I think Stephanie made this point earlier today. You can't come in with no cost. I mean, you have to have very good cost analysis and show what it costs, to show what you're spending, and show the proposed rates. And then we go to say, and here's why this proposal, you know, we cannot

Speaker 2 49:53

continue to operate. Yeah, I think one thing I would just add to that, 100% agree, it's every, every plans that. Tension when somebody says that's doing something like what you're doing, I'm going out of business. Because the next thing, I think, is where all those people are going to go when they can't go to your shelters and your network, they're going to go to the emergency room, and now it's costing me money there. And if they go from if they stay there a long time, that creates some political noise, right for me as a health plan, because that's not where people want them, Ed boarding and all those things, right? It's all the other system jails, another place that people end up going to. And so I think you have to, you have to show that picture if you want them to show up in your EDS, and you want them to show up in your jails and your county jails and in your prison, if you want all those systems overflowing because you couldn't help us figure out this piece right here, adding the code. North Carolina has that code as well for that, that in our SDOH programs. I think that's part of the narrative, right? It's it's all the cost, but it's also the consequence. Thank you.

Speaker 5 51:06

Thank you. Another question. I Cindy, I really enjoyed listening to you talk about early prevention and your program for for youth and children. I think what you said, zero to five. I'm curious about that. In California, I've been working with UC San Francisco on bright futures and the AAP bright futures. And I'm curious the model that they've come up with is twofold. One is a clinician in the room with a pediatrician, and then navigator to help with SDOH issues. I'm so curious about what you've come up with in North Carolina, and how that, how that's working, and what, what outcomes are you using, not just volume and numbers of people, but actually, what are you showing in terms of evidence that it really is improving people's lives?

Speaker 2 52:01

So so for the child first program that I mentioned this morning, some of the so the longitudinal aspect of that is the cost of care over time for kids that got that intervention, versus the cost of care over time of kids that didn't right, that ended up in foster care, out of home placements, that ended up in group homes. Prtfs Really high cost when they when they got to be early adolescents, and what we know from the data is that those kids that got that early intervention service, they looked the same in that zero to five window, but when they got to be 15, if they got the intervention, they're likely still at home, even though the factors are the same. You know, poverty, all those things. If they got that intervention, things were going okay. If they didn't, a lot of those are the kids that ended up in the out of home placement arena, which costs so much money, it costs a lot of money. So that's one thing we've looked at it longitudinally, which was part of what the evidence based model suggested is savings over time by getting this early intervention in place. So cost of care over time is one of the indicators we've looked at. Some of the other ones in the model for related to its fidelity are improved receptive and expressive language, improved matern The parents. Some of the mothers in this particular model have maternal depression or substance use and so it's the treatment that the mothers have engaged in and their outcomes in treatment, because they got introduced through child first. So child first continues doing its thing, while mom also goes into treatment for her maternal depression or substance use disorder, so it's tracking a lot of those kinds of outcomes. Off the top of my head, we're going to be doing a child first presentation and Long Beach, I think so come to OPEN MINDS for child first in Long Beach in August. That's a plug for Monica. It's a great it's a great

model, though. The other thing that we did, and this is more in the IDD space, is we have an in lieu of definition, called Family Navigator, and it uses parents of children with IDD. We also have family partners in the behavioral health space, but, but for IDD, we have such any child or or person, in fact, it's adults too, with IDD can have family navigator. So it's a parent of a person with IDD helping another parent to navigate the IDD system. And that's the whole system, whether it's hospitals or healthcare or service delivery or IEPs or whatever, and those family navigators. So we have several partners that deliver that we pay for it. That's basically what we do. We did create it as an in lieu of definition, and is wildly successful with those families. It's a small number of families that actually access it, but their cost of care and quality of life is a tremendous. This amount better because they were able to get that assistance and navigation other questions.

Speaker 1 55:10

And we have time for one more question, and I'll ask so you know, last fall, we did our at home care summit, and one of the statistics that shocked me was the highest growing group of homeless and housing insecure people were over 60 bucks and the and then they were going through all the financial pieces to all of that. But I guess one question, we haven't talked a tremendous amount about housing as a social determinant, but I was just curious, kind of from the North Carolina perspective and humans perspective, any work that you're doing in the housing domain, and Stephanie, how about you like, I know you pay, you know, the 65 plus population gets their allowance card that they can use for things. Are there housing related things in that benefit?

Speaker 7 55:59

So in that benefit, you can use it for things like utilities and some other minor kind of health house assistance. We aside from that, in the Medicare Advantage space, it is really more about maintaining independence in the home, rather than having to be institutionalized or just displaced into some place you don't want to live, maintaining that independence along the through, throughout the aging. So we've you know, we have different models to bring certain services into the home. There are certain assistance available for, you know, to make some slight modifications. We have some flexibilities to do that, particularly if it's tied something like falls prevention or things like that. So that's mostly in the in the Medicare space is around that independence at home in the Medicaid space, I didn't really, haven't really talked we do, we do Medicaid too, but we it is a bit more. We've made very large investments in housing. We have a part long standing partnership with Volunteers of America around a number of programs that are Co Location of services such as family focused recovery and things like that, to really build the capacity at the community level. So there's some different, innovative ways they do it there,

Speaker 2 57:33

right? So, so housing, I'm not going to talk about healthy opportunities, because I think Yvonne will cover that so on the housing, but it has a robust housing benefit. Some of the things Trillium is doing in the housing space, so with with adults with severe and persistent mental illness, and our IDD population, where we're working to help people have more independence using technology, right? That's one of our our big we have a product called Tula. It's trilliums ultimate Living Assistance that it goes into the home. It's just a device, but it helps with cognitive assist. It it helps with allowing people to get those assist, to

take their medication, to pay their rent. It gives them reminders of when to do things. It's programmed in conjunction with their with their health plan. It gives them the access to have a telehealth appointment right at home with other providers that are doing that through the device. It also has medical devices like high blood pressure or insulin, those kinds of things. So a page a person that we're care managing that may have a condition like that that needs to be monitored, we can monitor using this device with that person. So we have a deployment team that's working to get those deployed out into homes. And so that's one thing about just helping people stay at home live independently, so that they don't need to go into higher levels of care, which improves quality of life, a lot of other things. But we're also investing upcoming in this next fiscal year, in the development of some smart apartments with one of our providers, who happens to be here in the room, Easter Seals some apartment an apartment complex. It'll be a first of its kind for us, and I think maybe in the state that the apartment will be built with a mindset towards smart using smart technology and departments for the individuals who will live there, and and a universal design so whatever the disability or ability, it won't matter, they'll be able to use that technology to have the most independent life possible. And the reason for doing that is because, as we know, direct support professionals are not as plentiful. So what we really want is for folks that can use technology as a solution to do that, and so that we have enough direct support for the folks that absolutely need a human being to help them. And philanthropy was huge in that. Luann and I. Luann is the CEO for Easter Seals, Port Health in North Carolina. We work together with a donor of his estate to procure the land and some of the funding for this in his passing, which was credit to Monty. Rest in peace. He gave the donation for that as his last state. So that's another whole realm of philanthropy is and, and he actually found us and, and then we went on that journey with him to the end.

Speaker 1 1:00:35

Thanks for one last comment. There's any comments about the Healthy opportunities in housing? We have

Speaker 4 1:00:40

a robust housing service array in healthy opportunities for support services, rental assistance, relocation, all of that. So check out the fee schedule.

Speaker 1 1:00:52

Well, I can continue this all day, but we are out of time. Thank you guys. Thank you.