Delta Center Learning Session:
Making Your Case for Integration to a Payor: Insights from Missouri

Rachel Tobey [00:00:00] I am delighted to introduce to you two folks that many of you already know, Brent McGinty, who is the CEO of the Missouri Coalition of Community Health Centers, and Joe Perley, who is the CEO of the Missouri Primary Care Association. And I had the pleasure of coaching these two folks and their teams in Delta Center phase one. And when you all asked for more information on how to make an effective case to a payer, be it a Medicaid plan or a Medicaid agency or other government entity, other government agency, or integrated care and dollars for integration between primary care and behavioral health at the state level for training and policy purposes. These two immediately came to mind. So I am going to turn the microphone over to them and welcome, Brent. Welcome, Joe. Thanks for being alumni presenters at Delta Center today.

Joe Pierle [00:01:05] All right. Well thank you, Rachel. Appreciate the opportunity. And, Brent, did you want to make any more of an introduction?

Brent McGinty [00:01:13] No. I'm fine. Joe, with waiting for the presentation to flow. It's good to see everyone.

Joe Pierle [00:01:21] Yeah. So good afternoon. And, good morning to John from Alaska and to whoever else is west of us. So appreciate you being here today. Brent and I have given this presentation countless times and really enjoy, working together and going around the country and speaking to opportunities for partnerships between associations, but also partnerships between FQHCs and CCBHCs. If you can advance to the next slide. I always share that. This partnership has evolved over many years and it hasn't always been perfect. And it's probably not perfect today, you know. Brent and I can talk a little bit of time we spent in southern Missouri just last week fostering, partnerships between our, our members. So, when I started in 1999, the relationship between the Missouri Primary Care Association and Brent's organization was, pretty difficult. I was 28 years old going into management of an organization, and I had never really led anything. And Brent's predecessor was pretty tough on me. I didn't really even know what I was getting into in terms of running the PCA. I came from a policy background and worked on Capitol Hill, but didn't really understand the nuances at the ground level. But it became clear to me there was friction between our organizations, because at the time, FQHCs received a better reimbursement through Medicaid. And that really created a tense relationship. That person was succeeded by someone who now is the CEO of the largest FQHC/CCBHC in the state of Missouri. And we sat down and and started talking about how can we work together. So the first part of this presentation will go through various initiatives that we have pursued together, policy initiatives, but also real practical operational health care delivery initiatives. And then we'll talk about Missouri Health Plus, which is a clinically integrated network that focuses on executing value-based care agreements with payers. So, once we work through the tension and, you know, and I'm pretty blunt and honest, when I speak about these types of issues that we as human beings often are our own worst enemy, and we get in the way of progress. And I know you've all heard progress happens at the speed of trust. But I hear it over and over and I say it often, but I really think that that is a reality. You know, rooted, a lot of this is rooted in human nature and intention, and maybe not wanting to work with others and protecting our turf. And, to me, it's all just nonsense, because, I mean, Brent and I have approached this relationship, like, as we know that there are more Missourians who need access to care than what we can collectively

deliver. So why are we not working together? Or why are we trying to protect what we have? And. And it's not always popular when I say that, and I realize that, but, pardon me, I don't really care because it's, I really believe that we have to do a better job taking care of underserved. And we need to get out of our, our own self-interest and, and work together to enlighten that self-interest. We talk a lot about enlightened self-interest, and that essentially means that almost every meeting we go to, we go with our own self-interest, right? Whether it's us as leaders or us as a staff member or or our FQHC leaders and CCBHC leaders, they always go to meetings with their self-interest. But that self-interest can be enlightened when they win and their neighbor wins. And that's I would say that's foundational the principle that we have approached in terms of our relationship. So it started in 2006 when we simply, we had a governor at the time and a medicaid director and a chief medical officer, I think, Doctor Parks was of the Department of Mental Health. Which, funds, CCBHC. And I should share a little history. I'm sorry, I'm getting sidetracked, but I learned this just recently. Is that CC, CMHC and FQHCs or Community Health Center. Sorry, because FQHC didn't come and until 89. Like community health centers and community mental health centers kind of grew up at the same time. I think the CMHC were first under the Kennedy administration, and community health centers were next under the Johnson administration and the War on Poverty. But where we deviated and went separate ways was during the Reagan administration, when the CMHCs were block granted to the states, but the community health centers were not. So today my understanding is CMHCs received most of their funding from states. The community health centers received most of their funding from the federal government. And I think that's really important to remember. Because, I mean, I've shared with Brent and his predecessor that I always sometimes hear from my members is how come they get all this money from the state and we don't. And I would say, because we get a lot of money from the feds and they don't. So it kind of evens out. And just it's a level setting conversation. And, instead of us fighting about money, why don't we fight about what's doing right for patients? So we got this integration funding, to really starting forming partnerships between community health centers and community mental health centers. In 2006/7 and this funding exists today. It's it's survived many years of budget cuts when the state of Missouri was lean. But, our Medicaid director and our Department of mental health director and the governor all see the value in our two entities working together.

Joe Pierle [00:08:25] So the next slide will will show that our relationship evolved even further. And I would even say stronger and kind of dipping our toe in value based care where Brent's team and my, our team, got together with the state and develop. We were the first state to submit a state plan amendment to take advantage of section 2703 of the Affordable Care Act. And this has just been huge for our associations in our in our members. I can tell you, on the primary care side, our health center since received a significant PMPM on top of their FQHC reimbursement to take care of people with chronic illness. So we partnered together to bring this federal opportunity that passed through the Affordable Care Act to Missouri. It continues today. And I would say. It's still one of the most popular programs. Our Medicaid director highlights this as a success every time. And like I said, it was kind of our first entry into value based care, really focusing on better managing people with chronic diseases and then getting paid as a result of how well we do in terms of managing. And you'll see from that we've produced results to hospital and emergency room visits have declined as a result. So we're constantly rethinking this initiative. How to make it work even better. It is kind of. There's a lot of strings attached. And at a time when CCBHCs and FQHCs are really struggling with workforce challenges, we're trying to get the state of Missouri to reduce the burden expectations in terms of what types of providers we have to have on staff, to implement this initiative. But again, it's still widely popular among our associations and our members.

Joe Pierle [00:10:26] So the next slide. Our partnership has evolved. So that's a that's an advocacy, but also, a real practical implementation at the ground level, kind of changing how care is delivered at the ground level initiative. So we also got together, recently, to take advantage of opioid settlement dollars and have created partnerships between FQHCs and substance use disorder providers, some of which I think are also CMHC, but not all of the SUD providers are CMHC, but they're part of Brent's association. So that's just the next logical step, where again, we went to the attorney general, we went to the governor's office. We went to the legislature and and to put a claim on some of the opioid settlement dollars, because we knew that our both of our members were working to address the challenges of substance use disorder at the local level. So let's work together to get more resources, into our collective members, and you'll see the the partners that we worked with at the state level. Again, to make this happen. So that is of all to.

Brent McGinty [00:11:44] Joe. Can you hear me? Okay. Yeah, I'm coming through. I might mention this is one where I think, Joe, our relationship really the opioid settlement was a time where, the overdose crisis and and opioid deaths were just Missouri was really struggling and Joe's folks were really stepping up to the plate. It was an area that was tense. That could have been pretty tense for everybody. And I think Joe and I just realizing that, you know, it's it's time to get to that enlightened self-interest because we needed Joe's folks to provide MAT services, just like we were ramping up ours. And so going into that settlement money together, I think Joe was really helped relieve a lot of pressure on folks of how are we going to get money and pay for this and we had SOAR grant opportunities, which were great. But the opioid settlement money was really an incredible relief valve. And that joint advocacy, I think, really was, appreciated by everyone and was a really, I'm really proud of that one, Joe.

Joe Pierle [00:12:58] Yeah, absolutely. We could have fought over it, and we could have gone our separate ways and divide it and conquer, but we decided, let's bind together and and advocate together and leverage these resources together. Now, Brentt and I know that that his providers are going to provide care, you know, on their own FQHCs are building behavioral health programs and SUD programs. But the more we can combine our efforts and bring each other together to integrate care, the better. Which talk which the bottom part of the slide. We both have population health tools to we use Azara health care out of Boston where every EHR of the FQHC's connected to that system. And and Brent and his team, they use net smart, which I think is out of Kansas City. And I was told the other day that we're now that the two systems are talking. I wasn't aware of that.

Brent McGinty [00:13:58] Yes, that's what I hear, too, Joe. I think they're like at the kindergarten level, but they are speaking.

Joe Pierle [00:14:06] Yeah. Which is really critical because, you know, data is the new currency in health care, so the the better. We always talk about how we're drowning in data and starving for information. Well, we can get our systems to talk and then hire data analysts to make sense of this data, which we are doing. We can pursue other value based care initiatives together. We'll talk about that. So we are kind of in the infancy stages of getting the systems to talk and build out. But it's happening, which is really cool.

Joe Pierle [00:14:43] Next slide please. So this the relationship evolved even further. And I think I'm kind of losing sight of the timeline here, but I think this was two years ago now 2020. Boy. It might have been, I don't know, 22. I can't remember. But, FQHCs had capital needs. CCBHCs had capital needs. So again. This was actually earlier this was a 2 to 3

year process, where we went to our members, our respective members, and asked what their capital needs were. We combined the proposals, and Brent's team put together a really awesome looking advocacy toolkit and we went to the governor. And said, hey, we have 300 and something million dollars in capital needs. Outline where the impacts would be across the state of Missouri, whether it was a behavioral health project or an FQHC project or a joint project, because we do have several FQHC/CCBHC combos. We describe, we provided a description of the impact of each of those projects. We went through a legislative process and we got 150 million, which is not a small amount of money. Brent, his team got 75 million, and we got 75 million. And we are still. And then one thing I want to mention about a lot of these initiatives, a lot of the state money runs through our associations, and we're able to then. Build teams around health experts, community health worker experts, peer specialists, peer support specialists, in Brent's case, who can really help the health centers and CCBHCs implement different strategies at the local level. So that's just a little bit of a side note, but this capital funding was a huge success. And it's supposed to expire at the end of the calendar year, but we're working together to get extended through the fiscal year June of '25.

Joe Pierle [00:17:02] Next slide. or shoot I left out the the one slide that talks about how or maybe it's at the end, so where. So where are we today? Actually, I think it's at the end, so I'll tell you. Yeah. You know. Keep going. That's fine. That's kind of. The next right there. But this is kind of where we are today. The relationship has evolved to the point where we're going to build training and office space together. We're building a center of excellence or a center of health care integration and innovation. So we're really excited about that. We've got design meetings now. We intend to break ground in September of this year. It's been a challenge to find the right location, but we finally zeroed in. But at the end of the day, we're bringing our teams together. We're going to be housed together. We're gonna have significant training space together where we can bring in our CEO, CFO, COOs, medical officers, behavioral health directors, and so on and so forth. And we would do our own individual trainings, but we'll also have joint trainings. We have held joint trainings throughout the past many years around value-based care, etc. So we're really excited about this. It's taking off. And like I said, we're going to break ground in September and hopefully it'll be done by the fall of next year. So if you could go back to the Missouri Health Plus slide. So Missouri Health Plus is a clinically integrated network. And this this might be an old slide too, and I apologize. We can send you an updated packet. I think it might have more information, but it's a it's an integrated network of FQHC and CCBHCs. I think it's the only network that exist in the country. And a lot of PCAs are trying to build clinically integrated networks. Because we need to make sure that our, our FQHC and CCBHCs can excel in value-based care because it's it's not easy work. It's really difficult work. But we feel that, you know, by centralizing data infrastructure, data analytics, getting our pop health tools to talk to each other, centralizing contracting, that our respective members and collectively, we can succeed together and achieve shared savings and move HEDIS metrics and everything else that's required of us. Because we know that in many of our states, we have Medicaid managed care, and we do have Medicaid managed care in Missouri for everybody except the aged, blind, and the disabled, who are still fee for service. That all the burden and expectations that the state puts on the MCOs, ultimately, it's up to us to deliver. It's not, I would argue it's not really the MCOs delivering. It's it's our teams of professionals at the ground level who are delivering. So if we can centralize data infrastructure and analytics, offer delegated credentialing and so on and so forth, I think we have a chance to succeed. So the next slide, in the motivation for developing this structure was so that the belief that we're all stronger together.

Joe Pierle [00:20:41] So you can go to the next slide. And it's all about and the next slide. Sorry. It's all about leveraging our value together instead of the MCOs trying to pick off our members one by one and enter into agreements that many of the FQHCs and CCBHCs probably don't even understand. They're probably just signing the contracts. We felt that if we can bring us all together. We can do a lot of that centralized infrastructure type work and provide supports that our collective members need to succeed. So this was not an easy decision and it's still a work in progress. We have been able to make some distributions to the CCBHCs over the past 18 months. But this is the process that MHP's owned by the FQHCs and CCBHOs. I should start calling CCBHOs are participants to our Value-based contracts, and they have their own individual contract that we've negotiated lately so they can actually be successful and earn some money. But this this slide outlines the process that the FQHC owners went through. And and like I said, I, I would say I had about 90% of the folks on board. Everybody it was voted unanimously. Everybody voted, to support this. But there were some folks who who came along reluctantly.

Joe Pierle [00:22:14] So the next slide. And we can talk a little bit about foster care. Brent, I don't know if you want to touch base on that kind of our belief that if we can surround these kids with FQHC and CCBHCs for primary, medical, dental, behavioral health and SUD that these kids will actually have a chance.

Brent McGinty [00:22:37] Yeah, I think I might have added a slide. I might have added a slide to that point in a little bit, Joe. Maybe. But it it really is around some steps we're taking through Missouri Health Plus and, foster care, especially around behavioral health. But, I think it really might help us solve some of the data exchange issues with managed care and some of the issues around assignment of lives. And yeah, sorry for the CCBHO/CCBHC confusion. We are one of the eight original demo states, and CMS wouldn't let us put C in our name, because of where we put it in the rehab option. So they made us change it to O. But now that CBHC is in federal law, I don't know if we go back to the C or not. Joe. We just started learning to say O, and now we might have to go back to the C, but it is the same thing.

Joe Pierle [00:23:36] Yeah. Same thing. And I know our FQHCs don't really like the clinic word, so I thought that's why it was changed to O, Brent. But. But it is the same thing. And it's I would use whole Ovatus because I took six years of Latin. So I feel like I got to use a dead language sometimes, but that essentially means where are we going? So this highlights some initiatives. We've added the CCBHOs. To our network as participants to our value-based care agreements.

Joe Pierle [00:24:11] So the next slide. And the other thing is, you know, when Medicaid expanded in Missouri and we worked together to lead that effort to get it through, a ballot measure, it was a no brainer. I mean, we're adding all these adult lives. Many probably have unmet need. They probably haven't been to a primary care provider or dental provider, behavioral health specialists, probably ever. And they're going to be coming into the health care system. So why don't we work aggressively together to better manage to better manage these patients.

Brent McGinty [00:24:50] And Joe. I might, if they don't mind. I, I know there are a few states on here that was mentioned to me that were non expansion states. And so, you know, like Joe said, Joe was treasurer of the campaign to make that change in Missouri. And kudos to Joe for that service. But it was a tough lift. And recognize there are some states on here that don't have it yet. So I just wanted to put it on here though, that in the behavioral health space, we had a lot of success in Missouri before the initiative petition

kicked off for expansion in getting some waiver expansions for serving behavioral health clients. And and I always tell the story. Joe knows him. The doctor from Rolla who was so rabidly anti expansion state rep strong leader against it as a physician. And then he saw our waiver for adding behavioral health folks to Medicaid. And there are a lot of criteria to getting that done. And we had that waiver in front of the legislature and he said, Brent, isn't it just a mini Medicaid expansion. And when he said that word, we're like, we're dead. And instead he said, no, this one makes a lot of sense. I, I like this one. And so I, I throw that out. But while you may just have a strong feeling against Medicaid expansion, don't give up on those targeted waivers because that's a real opportunity that, CMS is kind of, investing in. And you might get somewhere, at least with something rather than losing the big, the big ask every, every year. But for those non expansion states, it is a, a difference for sure. And Joe and I have been blessed that they got that across the line vote of the people 52/48 if I recall. Right, Joe. But yeah. Yeah. So that was big. The other thing I'd warn folks is, Joe and I learned this lesson the hard way is that allotment of payment methodologies, as much as you can, is really helpful for value-based payments. And we've been a hindrance to Joe on some of these because. Medicaid has, just this is in the weeds a little bit, but the MCOs are in a fee for service reimbursement methodology with Joe, and the state makes what's called a wrap payment. And I'll get it a little bit wrong, Joe, and you can correct me, but to kind of make them whole against charges and that's a whole formula. And so that's all good because Joe's folks are competitive with all the other fee for service providers that the managed care companies use. So they they like using Joe's folks for, for the managed care. It's a, a competitive environment where they pay the same rate. Whether someone goes to Joe or someone goes to someone else. So it it generally is a level, level playing field and there's some nuance there. But that's generally the case. And with the, CCBHCs, when they designed our methodology, they made the managed care companies pay the full PPS, which is our prospective payment. So a therapy visit might cost them 70 bucks on some time unit code to another therapist, a private shingle one. But for a CCBHC, it might be 350 bucks. So even though they got more money in their PMPM to pay us that, it is a hindrance to adding additional lives or more value-based payments, into the system. So that's been a bit of a hindrance to our, Missouri Health Plus and some of our value based, efforts. So we're getting that changed in Missouri to kind of align the two methodologies. And I think for Joe and I, that's going to re invigorate, I think our conversations with managed care and and including around foster care. And I think one of the things we're really excited about because behavioral health data exchanges like Joe's got it figured out. It's not perfect by any means, but Assignment of Lives, they've got some really cool ways that they do that. And in the behavioral health space, that's been tougher. But we've got some work we're doing with home state around data exchange, where we're just really sharing just from the first time saying, send us this feed and we'll send your feed from our pop health, and let's start running some checks against the two data sets and see what we can come up with. And that that's been a real big game changer in home states. The one that has our foster care kid, managed care contracts. So I think, Joe, this between the payment alignment and the, some of the data exchanges I'm really excited about, kind of next steps with this, with the foster care kids. So, yeah, I wanted to go over some of that stuff because I know that was mentioned on the prep call.

Joe Pierle [00:29:43] Yeah, lots to digest there at that. That's very weedy, as Brent said. There's a lot of content with what Brent just went through, and we can dive deeper into this, too. I'll just talk for a second. Like we have a gated together that initially the foster kids were spread over all the plans in Missouri, and it was a disaster. This is the most vulnerable population at the state. I would argue they barely have a chance to be successful in life in the state. Stay out of the juvenile justice system and we have got to do a better job. We got to provide them better medical, dental, behavioral, SUD health care or

they're going to keep losing. And it's sickening to watch. Every year or so, we advocated that the state put all the children under one plan. So we could really track them and and track their care in making sure they're getting access to care, because it was almost impossible when they were spread amongst all the plans of Missouri. So that's a really critical, I think, take away. And as Brent said too that, some states, they require the MCOs to pay FQHC and CCBHCs the rate. And in Missouri it became. It was delegated to the MCOs to do that, but became a hindrance. The MCOs basically said, why would we assign our lives to you if you're a higher cost provider? So we went back to the state and advocated. To an old traditional way was the MCOs would just pay us a simple fee for service rate, and we would capture that and make us whole on the back end. And that's what Brent is working to accomplish, because we we want to be good partners with the MCOs. And even though, as Brent said, they got paid more to pay us more, they still are kind of challenging. As it relates to this issue. And, both of our teams are working feverishly to make sure that our pop health tools have all current actionable data so that the care teams. You know what care gaps need to be filled. When a patient is coming in.

Joe Pierle [00:32:03] And something that I'm not sure is on the slides, you can go to the next slide. Is that. Well, this talks about when we were weighing whether to allow CCBHCs to join our network. This is the opportunities and challenges we went through. And really, you know, it's the time and effort to build trust. That's the biggest challenge, right? That is always, to me, the biggest barrier to people working together. It just made total sense for us. We it strengthens our advocacy by working together. We bring more lives together. We bring a comprehensive set of services that we provide to the Medicaid patients together before the payers. We have an awesome opportunity to build out one of the most robust data infrastructures in the country by marrying CCBHC data with FQHC data and ADT data, and emergency all the data payer claim data, roster data, we have an extraordinary opportunity to to have an impact. But it takes time and effort and building trust to do all this. So last week, our teams got together in southern. Well, they call it "Missoura" down there, southern Missouri to, we brought the FQHC and CCBHCs together, and I gave an opening remarks. Within two minutes, they were cut me off and like, man, we want to work together. This is great. I was like, okay, I'm just going to stop talking because I don't know. It was really cool to witness, you know, I guess maybe I had lower expectations, I don't know. And Brent, unfortunately had to go to the capital and couldn't be there to witness it. But I'm sure his staff told him that it was a pretty powerful meeting. And we're really anxious to see what evolves out of that. We're going to let them drive it. They asked me for ideas, and I said, we want you guys to come up with the ideas. But, you know, one simple thing hopefully that could come out of this is if a that referral mechanisms back and forth. We're all resource challenged right. We know that there's more people who need care than we can meet the need of, even though many of us don't want to acknowledge that. I mean, it's just a fact, but we know that severely mentally ill patients die 20 to 25 years earlier than others because they often have associated comorbidities and chronic diseases. So what if a severely mentally ill patient shows up in an FQHC, and the FQHC has no idea how to deal with the person. Having the opportunity to refer them to a local CCBHC for more intense, care would be awesome. Or if a person, a severely mentally ill person, or just anybody who shows up at a CCBHC and they have severe dental decay or whatever it may be. Wouldn't it be really neat if they could refer that person to an FQHC dental program and get them in within a couple same day or few days? So it's all about focusing on the patient, not on our own egos, but keeping an eye on the prize and focusing on the patient doing the right thing. That's really what this relationship is all about. Yes, we and we want to be successful together. We want to make money through value-based care agreements. But if we're making money through value-based care agreements, that

means we're doing a better job. Integrating our care and providing better care to underserved Missourians. I think that's all I got. Brent.

Brent McGinty [00:36:05] I think that was pretty much the last slide. You know, so we have a great opportunity as associations. Like I said, we're meeting tomorrow morning with our architect to build out this space. And we really feel like Brent and I could be an example to our members that if we can do it. And again, it's not always going to be perfect. But we don't always have to be perfect. We can be less than perfect and still have an impact. And, that's what this is all about. So we'd be happy. I haven't been monitoring the chat or to see if there's any questions, but we're we're happy to answer any questions that you might have.

Rachel Tobey [00:36:53] This is Rachel. Can I ask a question?

Joe Pierle [00:36:58] Of course.

Joe Pierle [00:36:58] What have you found to be the most compelling message when talking with Medicaid plans that convinces them of the value of integration between your providers or between your associations? Just curious what messages have been sort of the most compelling.

Joe Pierle [00:37:22] Well, when you're with health plans, you have to talk their language, right. Do they have hearts? Yeah. They do. Do they want to? See people's quality of life improve. I think deep down they do. But at the end of the day, they're accountable to shareholders, right? They're mostly for profit. Not all of them. But most of them are driven by Wall Street. They're about making money, right? And there's nothing wrong with making money, right? Because if we didn't make money, we wouldn't be able to serve patients. So we want to make money too. So you got to learn to talk their language. We know behavioral health, especially as it comes to the expansion population. Adults who have never been served mostly or are likely going to have significant behavioral health challenges. So if we can get them into care, better, manage their care, keep them out of the emergency room because the emergency rooms don't know what to do with people that have behavioral health challenges when they show up. So Brent's got some very sophisticated programs and strong partnerships with, the law enforcement across the state of Missouri. So we talk about the various efforts we're doing, but we typically boil it down, is we want to help you save money and we want to help improve quality metrics. Because at the end of the day, that's what they're held accountable to by our respective states.

Brent McGinty [00:38:57] Yeah, we had a Missouri Joe. Isn't it like a 6% withhold? It's a 5. It's a pretty significant withhold. If I recall.

Joe Pierle [00:39:04] I thought it MCOswas 5, but I heard it was 3%. But that's $50 million that states often have, premium withholds on the plans. Essentially, what that means for Missouri's MCOs is $50 million is at risk. You know, if they can't prove that they're having an impact. They lose $50 million. So how do they how do they impact? How do they improve impact? They depend on us to do that. They can't necessarily do it themselves. They need us at the ground level to do it. So we're trying to get them to invest in us. And. This came up at the meeting down in southern Missouri, because one of the HEDIS metrics is about 7 and 30 day follow up for behavioral health. Once somebody presents at the emergency room and yeah, I asked all the CEOs I. And I said, what do you think about this? And no one thought it was attainable. So that gives us some homework to do and see if we can find a different heat metric or different expectations, and pitch that to the

mcos, potentially to the state of Missouri, because of the state is putting that expectation on the MCOs and it's not attainable. Then let's try to work on something that is more attainable and impactful at the same time.

Brent McGinty [00:40:30] And that's where you and Joe, the other thing I'll add is that relationship between Medicaid and the plans and us is just so important. And I feel like we've really worked hard at that so that we can communicate. So, you know, the plans want to report national HEDIS measures up to their corporate entities. Missouri can make some adjustments in the measurement because for behavioral health, depending on the staff that does the follow up, it could be a claim or it could not be a claim. Because as Joe knows, we send some non-licensed staff through some other programs to do follow up, but they are not counted because they're not in the claim. So the state of Missouri can capture that and give the MCOs credit. And that's that ongoing conversation that we got to have that going all the time. But and Joe, that is the United contract is the one behavioral health contract we've got so far is around the hospital follow up. But it's it's tough going right now, like I said, with that wrap payment issue. And like Joe said, being a high-cost provider, it's, a bit of an impediment, but I honestly do think, once that's resolved, I feel all the plans have been communicating. Once that's resolved, they really look forward to figuring out how we can do some value-based arrangements for the integrated network. Including foster kids.

Rachel Tobey [00:41:54] I'm curious if, given all of the data integration work that you've done and the success that you've already had in Medicaid, whether you are exploring either dual eligible or Medicare ACO type arrangements as well based on that.

Joe Pierle [00:42:17] So that's a conversation I need to have with Brent. We. So MPC. Well Missouri Health Plus was in the Medicare ACO business pre-COVID. And the Trump administration forced. ACOs to take downside risk. Okay, so back then we weren't as sophisticated as we are today and we were making a lot of money, but we didn't know how. So when the Trump administration said you got to take downside, we bailed. We got out, which was the worst decision, one of the worst decisions I've ever made because obviously Covid depressed utilization, total cost went down. We would have made probably quadruple what we were making prior. So it was a bad decision in hindsight. But we are getting back in the ACO space. Now, CMS recently put out an opportunity for CCBHCs. It's really kind of hard to understand right now. We talk with CMM often, and, Brent, I'm probably gonna have a follow up with them. It came up in a conversation, and none of us really know what how the mechanisms and how it's going to work.

Brent McGinty [00:43:36] But yeah, I think we're all kind of awaiting guidance on that. And I think we really, Joe and I briefly have talked about. I don't know if it's out yet. Hopefully my team will let me know. Kind of jointly partnering on that initiative, because we think it could be great to kind of use our, data integration and then really beef up kind of our value-based payment arrangements around including Medicare. And that's an exciting kind of opportunity there. So yeah, again, I say that because. We really try to avoid. Well, why can't we get part of that money? Or why can't? Well, let's work together and maybe we can come up with a stronger proposal if we to integrate both systems into the into the concept. So we'll be working on that together as well.

Joe Pierle [00:44:27] And Rachel. I can't remember the name of that. Yeah. I think it's behavioral health integration.

Brent McGinty [00:44:32] I think it's just BHI, Yeah.

Rachel Tobey [00:44:35] Is it just innovations?

Brent McGinty [00:44:36] Or maybe it's Behavioral Health Innovations

Rachel Tobey [00:44:37] I think it might be innovations.

Rachel Tobey [00:44:39] Yeah. Yeah. Yeah. But if that's the one you're talking about, you're right. Everybody is poised and waiting for the details to come out on that.

Brent McGinty [00:44:48] Yeah, they got a few calls, I think. Joe.

Joe Pierle [00:44:51] What's that?

Brent McGinty [00:44:52] I said, I think they've had a few calls that we've had staff on, but I think it's a lot of wait and see kind of. Yeah.

Brent McGinty [00:45:00] Yeah. Any more questions? I'm not sure who to turn it back to here.

Corina Pinto [00:45:23] You can turn it back to me.

Joe Pierle [00:45:24] Okay. Okay. Yeah.

Brent McGinty [00:45:27] Thank you all. It's good to spend time with you. Our peers across the country.

Corina Pinto [00:45:33] Yeah. Yeah. Round of applause as we can in zoom for Brent and joe, thank you so much for your wisdom and for the work that you all are doing.