Collaboration With Managed Care

“Are You Kidding Me?”

A candid, practical session on turning managed care frustration into shared patient-centered outcomes.

Ellen Williams RN, BS, CCM, CMCN, LSSYB

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Here is what we are really talking about

Not payer versus provider. Patient versus friction.

The friction

"Managed care called again? Are you kidding me?" Duplicate outreach, unclear lanes, and no closed loop create frustration.

The reframe

Managed care can be a partner when the right people share the right information at the right time.

The promise

Collaboration reduces duplicate work, supports continuity of care, and helps complex patients move forward.

Learning objectives / outcomes

By the end of the session, attendees will be able to…

1. Describe the roles of UM, CM/TOC, Behavioral Health, SDOH, and Quality.
2. Identify common friction points that lead to duplicate outreach and missed handoffs.
3. Apply strategies for shared criteria, contact pathways, case staffing, and closed-loop communication.
4. Recognize how SDOH, behavioral health needs, access barriers, and discharge challenges drive avoidable utilization.
5. Develop a simple collaboration framework adaptable across care settings.

End-of-day honesty check

Quick poll: what do you think when managed care shows up?

Audience prompt

Show of hands:

- Helpful partner
- More work for me
- I do not know who to call
- It depends who calls
- Are you kidding me?

No judgment. We are at the end of the day. This is a safe space for truth and caffeine.



Common myths that get in the way

If we do not name them, they keep driving the work.

Myth	Managed care only calls to deny things.	**Reality**	Collaboration includes care management, transitions, SDOH support, behavioral health, quality goals, and member engagement.
Myth	If I have talked to one managed care person, I have talked to all of them.	**Reality**	Different teams ask different questions and own different parts of the work.
Myth	More meetings automatically improve care coordination.	**Reality**	If that were true, healthcare would have been fixed years ago.

AUDIENCE ENGAGEMENT

What's Your Managed Care Horror Story?

No names. No organizations. No public shaming. Just honest experiences.

Discussion prompt

Every experienced case manager has at least one managed care story that lives rent free in their head. What is the most frustrating managed care interaction you have encountered?

The phone call that should have taken 2 minutes and somehow took 2 weeks

The fax that disappeared into another dimension

Five people working on the case and nobody talking to each other

UM, CM, and Quality: different lanes, shared destination

Utilization Management (UM)

Medical necessity, level of care, authorizations, concurrent review, appropriate use of services.

Case Management / TOC

Care coordination, barriers, post-discharge needs, member engagement, handoffs, and follow-up.

Quality

Patterns, measures, gaps in care, improvement priorities, and outcomes across populations.



Shared patient. Shared problem. Shared opportunity.



What the patient may be carrying

- Discharge instructions that do not match real life
- Medication access or reconciliation gaps
- Transportation, housing, food, or phone instability
- Behavioral health complexity
- No warm handoff to outpatient care
- Multiple teams calling without coordination

The patient does not care which department owns the problem.
The patient just knows they are stuck.

Why collaboration breaks down

Usually it is not bad intent. It is bad workflow.

No direct contact path

No shared criteria for who is in scope

Different definitions of urgent

No owner or target date

No closed-loop update

Duplicate messages to the patient or facility

Sometimes we think we are working from the same playbook - then discover everyone brought a different book.

The practical collaboration framework

1. Define the shared population

2. Exchange direct contacts

3. Agree on triggers and criteria

4. Staff the case with the right lanes

5. Assign owner + target date

6. Close the loop and document outcome

If I leave a meeting and do not know who owns it, when it is due, or what happens next, that meeting has become a social event.



Scenario: the frequent ED visitor

What shows up

- Several ED visits in a short window
- No reliable PCP follow-up
- Transportation instability
- Behavioral health overlay

What collaboration does

- Joint review with facility CM/UR and payer CM
- Identify access, medication, BH, and SDOH drivers
- Assign targeted outreach and follow-up plan

What shifts

- Right care setting
- Fewer duplicate contacts
- Clear next step
- Closed loop to facility

Scenario: extended length of stay / discharge barrier

The barrier is rarely just one thing.



Common barriers to name early

- Placement or level-of-care mismatch
- DME, transportation, medication access
- Guardianship or documentation delay
- Behavioral health or pediatric specialty needs
- SDOH barrier not visible at admission

Confirm owner, target date, next touchpoint, and what success looks like by then.

Scenario: behavioral health transition

The challenge

Medication needs, follow-up access, transportation, safety planning, and limited support.

The collaboration

Facility CM, payer CM/TOC, behavioral health, and SDOH supports align around specific barriers.

The outcome

A handoff that includes a person, a plan, a phone number, and a next step.

Discharge instructions do not drive themselves to the appointment.

Who should be on the shared radar?

Utilization and transitions

- Frequent ED use
- 30-day or rapid readmission
- Extended LOS tied to barriers

Risk and complexity

- Elevated readmission risk
- High SDOH risk
- Behavioral health risk

Clinical and pharmacy

- High-risk pregnancy
- Diabetes or cardiac complexity
- Medication access/cost/polypharmacy

The collaboration close-the-loop test

Can everyone answer the same four questions?

1. **Who owns the next action?**
2. **What is the target date?**
3. **What will success look like by then?**
4. **Who needs the update when it is done?**

If the answer is fuzzy, the handoff is not done yet.

Use data as a flashlight, not a hammer

Use data to find opportunity

- High-risk/high-needs lists
- Readmission patterns
- Potentially preventable ED use
- Follow-up care gaps
- SDOH indicators

Do not use data to create defensiveness

- Avoid facility scorecard tone
- De-identify examples when teaching
- Lead with shared patients and shared goals
- Ask what workflow can improve

INTERACTIVE EXERCISE

Table exercise: fix the handoff

Because it is late and nobody needs a 20-minute lecture on handoffs.

Prompt

A patient is discharging tomorrow. The hospital CM, payer CM, BH team, and Quality team all have partial information. The patient has transportation instability and no confirmed follow-up appointment.

In 3 minutes, identify:

What information must be shared?

Who owns the next action?

What is the target date?

How will the loop be closed?

Debrief: What would prevent duplicate outreach here?

A simple checklist case managers can take home

Lightweight. Repeatable. Actually usable.

- [ ] Shared population defined
- [ ] Direct contacts exchanged
- [ ] Criteria and triggers agreed upon
- [ ] Owner and target date assigned
- [ ] Warm handoff completed
- [ ] Outcome documented
- [ ] Closed-loop update sent

Ellen-ism

"If we do not close the loop, we did not collaborate. We just had a nice conversation."

What facility case managers can ask managed care for

- A direct CM/TOC point of contact or shared inbox
- Clarification on UM versus CM lane when work seems stuck
- Help with member engagement after discharge
- SDOH benefit navigation when available
- Behavioral health coordination support when indicated
- A closed-loop update when payer outreach occurs

What managed care needs from facility partners

The partnership works both ways.

- **Early notice of barriers before discharge day if possible**
- **Clear discharge requirements and critical-path blockers**
- **Accurate follow-up appointment details**
- **Best phone number/contact preference for the member**
- **Facility CM/UR contact who can close the loop**
- **A shared view of what changed since the last touchpoint**

Meeting cadence: less meeting, more movement

Cadence should create progress, not calendar clutter.

15-30 min

Weekly touchpoint

Start lightweight. Taper when workflow improves.

Each touchpoint reviews

- Top barrier cases
- New LOS or discharge outliers
- Assigned actions with owner and target date
- What changed since last touchpoint
- What must happen before next touchpoint

REFLECTION

What Surprised Me Most

The biggest barrier was not willingness. It was workflow.

What I expected

Resistance. Turf protection. Organizations not wanting to work together.

What I found

Most people genuinely wanted to help. They simply lacked a clear pathway, owner, timing, or next step.

What changed the work

We stopped asking whose responsibility it was and started asking what barrier we could solve together.

Audience reflection: Think about one collaboration success you have had recently. What made it work?

TAKEAWAYS

Five things I hope you remember

If you remember nothing else...

1. **Managed Care Is Not One Team**
2. **Communication Fails More Often Than People Do**
3. **Shared Patients Require Shared Accountability**
4. **Collaboration Reduces Duplicate Work**
5. **The Best Collaboration Is Simple: know who to call, assign an owner, set a target date, close the loop**

Q&A

What is one collaboration friction point you would fix first?



"Managed care collaboration is not magic. It is people, pathways, timing, and follow-through - with a whole lot of patience and maybe a little coffee."

Thank you