

**Medicaid Innovation Accelerator Program (IAP)**  
**Physical and Mental Health Integration**  
**Addressing Administrative and Regulatory Barriers to**  
**Physical and Mental Health Integration**  
**March 26<sup>th</sup>, 2018**

[Intro]

Laurie Hutcheson: Policy fellow with the National Academy for State Health Policy (NASHP), facilitator.  
Agenda:

- Brief overview of the Medicaid Innovation Accelerator Program Initiative
- Aligning state functions to support integrated physical and mental health care
- Arizona and New York on their efforts to overcome administrative barriers

Presenters:

- Melissa Cuerdon, Health Insurance Specialist, IAP PMH Lead, Center for Medicaid & CHIP Services
- Kitty Purington, Senior Program Director, NASHP
- Tom Betlach, Medicaid director, Arizona Healthcare Cost Containment System
- Shaymaa Mousa, Office of Primary Care and Health Systems Management, New York State Department of Health
- Trisha Schell-Guy, Deputy Counsel, New York State Office of Alcoholism & Substance Abuse Services
- Keith McCarthy, Director, Bureau of Inspection and Certification, New York State Office of Mental Health

Melissa Cuerdon: Medicaid IAP is a technical support program funded by the Center for Medicare & Medicaid Innovation (CMMI) and led by the Center for Medicaid & CHIP Services.

The goal of the program is to increase the number of states moving towards delivery system reform across program priorities. The priorities that we focused on are beneficiaries with complex needs, substance use disorders, long-term services and supports, and physical and mental health integration. We also have functional areas that we work with in supporting states' needs in delivery reform efforts.

In the PMH program, we worked with nine states over 12 months to enhance and expand integration efforts. We focus on topics like administrative alignment, which we'll hear about today, payment and delivery system reform, quality measurement, and best practices in coordination of care of services.

This is our last webinar for the national dissemination part of our track.

The teams that we worked with for this track were Idaho, Illinois, Hawaii, Massachusetts, New Hampshire, New Jersey, Nevada, Puerto Rico, and Washington.

Laurie Hutcheson: Kitty Purington will discuss state functions that should be aligned to support integration.

Kitty Purington: I am going to be providing a very brief overview of some of the things we have learned from working with states as part of this IAP track and some themes our speakers will be touching on later on.

First, I find it can be helpful to define terms in this arena. States are doing a lot of different things under the rubric of integrated care. What that actually means can differ enormously really depending on the target population or the setting, the Medicaid authority being used, and just a host of other factors. For this IAP, we found it helpful to think about integrated care generally as a set of components that can be adapted or supported by state policies in different settings. The AHRQ Lexicon was a tool that we referenced frequently and has been helpful as a broad description of what is needed to support integrated care. The Lexicon was developed with primary care in mind but it can be helpful for state policymakers, especially in thinking through what is needed and what is helpful for both primary care but also other settings as well. This slide outlines some of those components drawn from the Lexicon work, and that the states will likely need to consider when thinking about the administrative structures necessary to support integrated care.

Some of the things states have been working on are:

- The capacity to identify and screen for behavioral health issues, where that takes place. Can it take place in primary care?
- How to support multi-disciplinary teams—is this doable within fee-for-service? Is it something that a state needs per member per month?
- Methodology to support things like care planning and care coordination. Is this for a target population or through an enhanced primary care model such as a patient-centered medical home?
- Evidence-based practices and protocols. Is the state looking to support a particular model such as SBIRT or collaborative care, or again looking at ways to support specific functions and components?
- Access to data.

This slide previews a lot of what the states are going to be speaking about and represents kind of the ideal state for supporting integrated care, starting with the clear vision from leadership that sets the end goal, describes the kind of changes necessary, and critically, really empowers state agencies to make what can sometimes be very challenging changes to the status quo. A theme we will be hearing about is the importance of leadership.

Moving beyond the particular Medicaid state plan or Medicaid authority that can provide the vehicle for payments, but looking also at how to adapt or develop state regulatory structures that can support integrated care. So licensing, Medicaid regulatory structures, state-managed care contracts and other policy levers, how do they all work together to support integrated care? Some of this can happen at the structural administrative level and then other work really needs to be a systematic review to identify and remove specific barriers.

Finally and critically also, is there a realistic pathway for payment? While payment is not the only thing needed for the shift to integrated care, without it you're just not going to be able to buy the services that you need. At the end of the day, ensuring that providers get paid for services, is clearly an important priority.

What we'll also hear today is the real need for cross-agency collaboration. Why isn't this the natural state of things? We know states have a lot of different ways to administer services. They may have

single or multiple agencies. They may have divisions between physical health and behavioral health services. Some states have substance use disorder administration carved out into its own separate agency. States may also have a managed care organization with behavioral health delivered through fee-for-service or have some general behavioral health benefits carved into managed care, or have a separate behavioral health organization that manages those services. How services are organized in this way really has an impact.

Then we have all the different pieces of the puzzle that hold the system together that we'll be talking about today. In particular, it may or may not be a line to support integrated care. Again, things like regulations, contract language and licensing, what is the interplay of all these different pieces of the puzzle with how providers are delivering care and how they're getting paid for it?

This is some of the commentary to look out for. Some of those from our speakers involve regulations from various state agencies that may have very different requirements depending on the setting. For instance, behavioral health services often have very specific plan of care or review requirements that may not translate easily into a primary care setting. Licensing requirements for professionals but also for facilities can be complicated. They can be duplicative or overly burdensome and sometimes just plain conflict. Similarly, billing can contain additional barriers. Who can bill for what code is often spelled out in regulations or managed care contracts. States may have same-day billing restrictions or providers may perceive those restrictions. There may be other barriers to payment. All these can often have a very particular impact on federally qualified health centers (FQHC) in particular.

Finally, states may have additional privacy regulations. Certainly, HIPAA and 42 CFR Part 2 need to be taken into consideration when supporting integrated care, but layered on top of that often are state statutes and regulations that can become real impediments to care coordination, to referral, or may just be very costly to implement outside of specialty settings.

During this webinar, we are going to be hearing from two states, Arizona and New York, which have taken a deep dive into the administrative and regulatory structures of their states to identify and eliminate barriers to integrated care. Some of the strategies they have used and are using successfully are:

- Prioritizing integrated care at the leadership level.
- Very deliberately and thoughtfully engaging with other agencies that need to be at the table—licensing, Medicaid, behavioral health, and really thinking through who may hold a piece of that puzzle that needs to be part of the conversation.
- Taking a very systematic approach to reviewing licensure and other structures. Not just reviewing but really proactively identifying barriers and also often having stakeholders including providers at the table to really figure out how is this operating in the real world.
- Keeping an eye on how all this work does or does not help providers get paid for what is really the goal, which is delivering care in a new way.

Laurie Hutcheson: Tom Betlach is going to talk about how Arizona has aligned state functions to better support integration.

Tom Betlach: Glad to be here to share our 6-year journey in 15 minutes, so we'll condense a lot. Just a little background information. Arizona had a carve-out in place for 30 years since the inception of the Medicaid program that was administered by a separate state agency outside of the Medicaid agency. Both those agencies came together. We're going to walk through the evolution and change we went through as part of our integration efforts, and to focus on integration and looking at the opportunities.

But first, in terms of being able to address and change that drive, change can be so difficult. One of the commitments we made early on was to communicate, both internally and externally, to all of our stakeholders on the need for change and why change was so important in terms of the delivery system. We focused on the history and the poor outcomes associated with some of the specific populations we serve and the need for change there. We focused on the complexity of the population and how system design matters, and the need for change to improve that system design.

Then we had just been through the Great Recession and folks were very familiar with the very difficult decisions we had to make, so we focused on the sustainability aspects of the Medicaid program. We'll talk a bit about three levels of integration. I appreciated the description earlier in terms of all the different aspects of integration, and in Arizona we've often talked about three levels—a policy level, a payer level, and a provider level. We'll talk about:

- The dynamics we face in terms of two state agencies working on those efforts together.
- What ultimately led to the merger, and some of the dynamics around that cross-agency collaboration.
- The process we went through in terms of the merger and what that looked like, and how that's evolved over the last couple of years, but really having to go into that without a great blueprint for state government in terms of what does a merger look like when you're talking about 100-150 different positions.
- What the future holds.
- Some of the lessons we learned going through that journey.

I mentioned at the beginning that in order to start driving this change in the system we needed to be able to provide clarity for folks in terms of why was it that we were pursuing change. First, there was the study done identifying that individuals with serious mental illness on average in the United States die 25 years younger than their peers and in Arizona that was 30 years. Quite frankly, for all of us that's an unacceptable outcome. It meant that we needed to look at how we were structured, how we were doing business, and what can we do to improve our systems for better serving that population.

We started with the mantra that system design matters. So if you have individuals with serious mental illness, and Arizona is a mandatory managed care state, and those individuals were served by one managed care plan for physical health services, another managed care plan for behavioral health services, we knew that 40% of our individuals with serious mental illness were also dual eligible members, which meant you had Medicare fee-for-service and Medicare Part D at the table, or a Medicare Advantage plan. That type of system design really resulted in lack of accountability, lack of alignment in terms of the managed care organizations serving that individual, and far from a comprehensive system in terms of what could we do to improve outcomes for our population we were serving.

The second aspect of this is just when you look at the Medicaid program in general, and GAO did a study and it identified a few years ago that 5% of the Medicaid population equals 50% of the spending. That's not surprising to folks that deal with insurance products. But what I thought was really helpful in that study was the diagnosis level information on that 5%. When you look at individuals with asthma, 24.5% have diabetes, 65% have a mental health need, and 29% have substance use disorder. You can see pretty quickly in terms of looking at this table the strong correlation between this group and the top 5% that equals 50% of the spend between a behavioral health need and a chronic condition in long-term services and supports. Yet in so many of our states, we had created systems in who those different services were managed by different organizations. So for us again looking at system design, looking at

the need to change, this type of data only further reinforced our messaging around the types of integration efforts we wanted to pursue as a state.

A third (aspect) was around sustainability. We're all familiar with the fact that Medicaid as a percent of general fund budgets has grown significantly and continues to grow, so that for us, we recognize the difficulty this puts policymakers in. So we need to make sure that Medicaid is a sustainable program going forward so as part of that again it comes back to system design, back to the need to change. This became really three major talking points for us in terms of talking to staff, to providers, to advocacy groups, to the Legislature, to the leadership around really looking at communicating the vision of where it was we needed to go around integration and why.

I mentioned earlier integration. I think of it and we talked about it in Arizona as really three levels. AHCCCS is the single state Medicaid agency in Arizona. Under the old configuration we contracted with a sister state agency, Division of Behavioral Health Services within the Department of Health Services, who contracted with a series of organizations, Regional Behavioral Health Authorities, who really had their own separate group of providers that delivered behavioral health services. On the left-hand side, we contracted with plans that provided physical health services. They had their own group of providers. At the end of the day, this type of fragmented delivery system meant that providers rarely communicated with each other or did care coordination; that managed care organizations rarely talked to each other in terms of really providing the best care management for individuals; and at the end of the day it is largely left to the individual, the member, to have to coordinate between the series of providers.

So we've pursued a variety of efforts to really focus on integration at the provider level, the payer level, and the policy level. So today's conversation is really focused on that policy level and how were we going to look at the delivery of integrated services in the most holistic fashion? That meant for us as a state we needed to work more closely together in terms of the relationships we had with our sister state agency. The problem was when we started this effort five years ago, that relationship was not very strong. In fact, it was very weak and very ineffective, and there are several factors listed on this slide. But there was very much a lack of trust between the two organizations at the staff level and leadership level. In Medicaid in our role as a regulator when we were contracting with the sister state agency, we were viewed as that inflexible regulator. We viewed our sister state agency as having limited capacity if we were going to do integrated efforts at the payer level and support provider integration; we didn't think behavioral health was necessarily having the right resources to be able to stand that up. But we also found out pretty quickly that Medicaid was far from an expert, the Medicaid agency AHCCCS, and found that our staff knew very little about our behavioral health system. We knew very little about what it meant to have a recovery-oriented system and peer-led services. That type of dynamic made it very difficult for us in terms of being an effective regulator and an effective collaborator with our sister state agency.

There was significant duplication of infrastructure by having two organizations involved in the delivery of these services. We have a whole series of reports prepared by state agency staff that were reviewed by other state agency staff, and all the other infrastructure in terms of managed care organizations, providing encounter data to one state agency to turn around and pass it to another state agency. Both agencies being involved in contracting with analytic staff and actuarial staff and clinical staff. So a lot of duplication in terms of that type of structure, as we really dug into what could we do to improve our overall efforts.

Then the realization that if we wanted to address many of those things that were discussed previously around billing policy or coverage policies or supporting providers in terms of their efforts around

integrated, that we needed to be able to speak more holistically in terms of our approach to integration from a policy perspective.

So very briefly, we went through a process in terms of we started in 2013 by integrating services for individuals with serious mental illness. The contract was stood up in April of 2014 and that was stood up on the behavioral health side. So we had managed care organizations serving that population that were integrated. We came to the realization quickly that we wanted to also look at policy merger to be able to integrate there. It was included in the 2015 executive budget and throughout the 2015 session we actually had legislation that was enacted unanimously, that I think was quite an achievement in terms of when you looked at historically this had been something that had been discussed but had been rejected every time down at the Legislature by concerns both from providers and advocacy organizations. I think it spoke to our growing efforts in terms of really being able to partner externally with those stakeholders around trying to improve the delivery system to better serve our members.

We completed the merger on July 1, 2016 to add about 140 staff to the Medicaid agency staff. That merger process again was pretty unique in that there was no blueprint for state agencies to really go look to how you want to execute this. So we dedicated two project managers, one from each agency who had spent a lot of time in state government. They did a wonderful job and were really the keys to our overall success in terms of wanting to be able to establish the subcommittees and get those subcommittees to make decisions in terms of how to deal with system issues and all the legal issues. We had over 100 different contracts we had to change the name on and make sure we were incorporating correctly. Just dealing with the spacing issues and how to bring staff over and find space for the staff.

The other important aspect was both agencies said right away “We want to integrate staff. We just didn't want to bring over a Division of Behavioral Health Services and create a new Division of Behavioral Health Services within the Medicaid agency.” For those staff that were overseeing managed care organizations, we wanted them to be with the part of the agency that was involved in seeing managed care organizations. For the part of the organization that dealt with tribal members, we wanted that to be with the other part of the agency that dealt with tribal issues. So really looking at this in terms of integrating within our organization and not just creating a new division.

Finally we stood up a steering committee that had input from managed care organizations along with provider groups to look to see where we could reduce the administrative requirements on providers and managed care organizations. We came up with a detailed list of strategies we effectuated from data reporting to assessment criteria that were required previously to be placed upon the providers within the system. Then also just to get rid of several different other types of reporting requirements that had previously existed. We also held public forums throughout the process to get public input as part of that merger process to see what type of additional things we needed to be considering at the state level.

So it was incredibly important I thought to really establish early wins throughout this process and to identify those types of things where we could say to folks see, this merger is really making a difference. The first is that we took an organization that was within our sister agency that had an Office of Individual and Family Affairs and a Human Rights Committee along with human right advocates, and we brought them into our organization. We created a new division. We really leveraged their ability to get out into the committee and have a whole variety of stakeholders that they met with on a regular basis. So as you went through this merger process, it was important to identify the strengths of each organization and the weaknesses of each organization.

It was clear that our sister agency was very strong in terms of being able to work with stakeholders, get input from stakeholders, in a very structured format, and have very important conversations with

member stakeholders' family and advocacy groups. To have that type of capability really strengthened our organization to be able to do that going forward.

We also looked at the ability to take that organization and use that in a real-time fashion to impact how we regulated our managed care organizations. So we created a monthly meeting by which we were able to get this feedback loop to say hey, we've got a provider in this part of the Metropolitan Valley that's really struggling in terms of serving members. Or we've got an issue we're hearing in terms of a court-ordered evaluation process down in Pinal County. So there was a list developed of issues that this office was hearing about, and for the first time in my tenure here, which had been about 12 years at the time, we were able to get this structured feedback loop that we turned right around to be able to improve how we engaged managed care organizations, how we engaged previous, and how we improved the delivery system in almost a real-time fashion. I think that was an early win from the merger process that we were able to explain to a variety of different stakeholders about the importance of how that merger played out.

There was also the ability to leverage behavioral health expertise in a way that we previously never had within the organization. We saw the ability in terms of new contracts and being able to put requirements in around behavioral health for managed care organizations that quite frankly we never would have had the expertise to do before without having gone through the merger. We had stakeholders sitting at the table around new policy development in a fashion that we never had before. For those providers and advocates in the behavioral health community that had to work through a sister state agency and then eventually get to the state Medicaid agency, it removed that whole step, brought folks directly to the table, and they were able to engage in policy development in a way that they never could before.

One of the most exciting aspects for me as the Medicaid director was I all of a sudden had this new capacity and new staff and new resources to address issues that we never had before. So with the merger we had housing staff, employment staff, grant staff, folks that focused on our crisis system and peer services. So for a Medicaid director who never previously had that type of capability within the organization, to sit down with that staff on a very regular basis to look at the strategies that they're deploying and to be able to leverage that across all of our different lines of business, to be able to create new partnerships with other state agencies like the Department of Housing, to leverage our relationship with vocational rehab and find additional resources to really drawn down additional federal money around employment support for our members, was just a leverage point that we never had in the past. It's incredibly exciting to have that type of capability within our organization.

Some other early wins for us were really the training that we could do for our own staff internally to grow their expertise and to grow their understanding of our behavioral health system. So I mentioned crisis system. There was very little knowledge within our Medicaid agency that we actually have a pretty robust crisis system in Arizona. We needed to take that fully into consideration as part of our overall integration efforts so that as we moved into blending and braiding payment streams at the payer level and supporting provider integration that we don't do anything to upset that solid infrastructure we had around 24x7 call center, rapid response, stabilization beds. We just provided a whole series of this type of training opportunities for staff to learn about the broader delivery system that we are expected to manage and improve here in Arizona.

We've also done a lot of work at the policy level around supporting providers on their journey to integration. So we worked to reduce the regulatory burdens for providers. We created a specific designation of integrated clinics. We increased funding for those providers that moved to an integrated clinic where we increased our fee schedule by 10% for physical health services, recognizing that

providers oftentimes as they were moving to integrated entities, it required (a) more time to spend with the member but (b) also they were seeing the more complex members. We were also able to fortunately set up a new waiver. It's not as significant as New York's DSRIP waiver but it's \$300 million in targeted investments, which we're largely using to support providers on their integrated journey. Again, the ability to have all that expertise within our organization, to look at our vision and how this further executes our vision, was incredibly important as part of being able to carry forward that targeted investment, \$300 million, and get those funds out into the community.

We supported an effort through our merged organization to work with our statewide Health Information Exchange (HIE) and find funding to get our 90 largest behavioral health providers connected to the state HIE. So whenever I go out to behavioral health providers, they're always incredibly excited about their ability to see members in a real-time fashion who have hit an emergency department or inpatient setting. It just gives them visibility into the delivery system in a way they never had previously.

We've been working to resolve billing issues around tele-health and same-day billing, working on clarifying policies around non-emergency medical transportation, which has been an important issue for behavioral health providers who have provided this service. We continue to look at how we have in Arizona some pretty robust behavioral health services but then how do we incorporate that consistently across all our different lines of business within all our policies going forward.

In the future we're going to continue to look at our staffing integration efforts and to build on that. As a result of the merger we've had staff wanting to come in and join the agency because of the opportunities from an integrated setting. Having the structure in place was incredibly important for a process we just went through. We were awarded \$50 billion in a 7-year managed care contract that will fully integrate services for about 1.5 million of our 1.9 million members. It continues our vision and continues those efforts in terms of addressing social and economic determinants.

So the early lessons learned, and I think this really applies whether or not you actually go through a merger like we've gone through in Arizona, or if you're just looking to make and address policies at a more holistic fashion at a state level across multiple organizations:

- In order to deal with the conflicts that naturally arise from these types of issues, leadership has to engage in a very sustained fashion. So in order to support staff, we got together on a very regular basis in order to resolve issues and to make sure we were making progress in terms of all of our short win commitments.
- That we continued to communicate what our vision was internally and externally throughout that process.
- That we looked to leverage each other's strengths. So for us even before the merger, to consolidate some of the Medicaid data and leverage our platform to do that, and for DBHS, our sister state agency, to leverage that relationship capacity that they had.
- To find a vision, generate short-term wins. Very early on we had a series of short-term wins we wanted to achieve even before the merger and to follow that up in terms of our operations moving forward.
- That learning opportunity. I have staff always that come back to me and really appreciate the ability to learn more about the delivery system and better understand how behavioral health is delivered within the state of Arizona but more importantly how we're driving towards integration and what that looks like. Taking those opportunities to train staff and train providers and to engage others as part of that process.

Those are lessons for any type organization regardless of whether or not you're merged. I'm short on time and covered many of these topics. One thing I will mention is throughout this process the member voice was strengthened throughout this. Again that was a strength of our behavioral health system but we've now seen that play out throughout our delivery system, and really encouraging our organization to hear from members in a way that we previously had not. At the end of the day when you look at the positive outcomes, clearly there's a variety of different things we point to in terms of our success, and we're far from done in Arizona. But to make sure that the member has a voice in terms of all the change that's being driven into the system I think has been incredibly important. Questions?

Laurie Hutcheson: *Did the merger result in cost savings to the state?*

Tom Betlach: It resulted in some very modest cost savings. It was less than \$1 million. But when the Governor's Office pursued this it really wasn't about the cost savings as much as it was just reducing the duplication that existed within the two organizations and resulting in an overall strengthened Medicaid program. But there were some modest savings.

Laurie Hutcheson: *Can you say more about how you were able to use managed care contracting to get new resources to providers and that may have helped you address some of the regulatory challenges?*

Tom Betlach: There are a couple different strategies we used to leverage additional resources. One is we required our managed care organizations to enter into value-based arrangements, and oftentimes it's integrated providers that stand to benefit from those types of value-based purchasing arrangements. So when you look at the ability to impact—and again I think this is because we've been able to braid a variety of different funding streams—some of those value-based arrangements are very creative. There's an assertive community treatment team that deals with forensic patients, 300 individuals with serious mental illness that have justice system involvement. Because we've been able to braid together a variety of different funding streams, the managed care organizations have been able to look at things like housing, justice involvement, primary care, along with behavioral health utilization. So the integration efforts, the value-based requirements efforts, have allowed us to really address that in a much more holistic fashion. That requirement then allows more resources to be at the provider level to support those higher outcomes. That's one thing.

A second thing is all the targeted investment dollars, that \$300 million I talked about, that's moving through the managed care organizations, when we increased the physical health reimbursement for integrated clinics, all of that was put through the managed care organizations, so there were additional resources that were required there. Then in some populations we've been able to braid in other funding like the voc rehab employment dollars, dollars provided by the Legislature for housing, all of that sits with the managed care organizations. So they're able to really do very comprehensive coordination around a full array of services for individuals. The other one I mentioned was crisis system. We've gone about \$175 million that we spend on crisis. Medicaid covers about three-fourths of that in terms of our crisis system. So those are all resources that flow through our managed care organizations.

Laurie Hutcheson: It may be too soon for this question, but: *Can you talk about any health impacts of integrated you observed or have evidence of yet?*

Tom Betlach: Right now Mercer is doing a formal evaluation of the program so I don't have any specific data yet. But I included in the presentation some of those value-based arrangements are a few quantified areas. I know when I've talked to the managed care organizations they have some data on increased utilization in primary care for individuals with serious mental illness who we had seen clearly underutilization of those resources. But we're going through the formal evaluation process now.

Laurie Hutcheson: *Were there any duplicate positions between the two agencies that were subsequently eliminated, and were there any negative repercussions of that?*

Tom Betlach: There were duplications in terms of positions but we really didn't eliminate them. We offered them other opportunities that existed within either our organization or the Department of Health Services. We didn't really go for any formal reduction in force as a result of that.

Laurie Hutcheson: *Can you elaborate on the steps to getting to integrated clinic designations?*

Tom Betlach: It's a regulatory structure that exists. Our Department of Health Services has the criteria around that. So it's basically an outpatient clinic and there are a few other obvious requirements around that. But once you have that designation you provide that to the Medicaid agency, and we have a separate provider type for that and there's a separate fee schedule for that so you get the enhanced physical services reimbursement.

Laurie Hutcheson: *Can you say a little more about what you think a state that's not necessarily merging functions can accomplish to better align its organizations and agencies to promote integration?*

Tom Betlach: I think organizations that are not going to merge can do several things. One is to identify a joint vision of what they're trying to accomplish, to identify joint strategies around that in terms of what's going to support that vision, and then beyond that, I was amazed at the amount of learning we did between our two organizations really to strengthen our own staff's understanding of the delivery system. So taking that opportunity to make sure that the Medicaid agency that may not have a full appreciation of the behavioral health system get that opportunity and vice-versa. Then the other areas—this comes under strategies, I didn't mention it much in the presentation—but we now have all the SAMHSA grants under that. So where do you leverage the SAMHSA grants as part of trying to tie in directly with Medicaid. We did that specifically on the STR opioid funding where we grew capacity. We followed it up in terms of increasing capitation rates and pulled our managed care organizations where they needed to use that expanded capacity to provide more treatment for individuals with substance abuse. Those are some specific examples states may want to focus on.

Laurie Hutcheson: One last related question: *Would you say that any of the early wins you described are achievable even without moving towards the full merger?*

Tom Betlach: Yes, I do. I think that state government plays the critical role in policy development, whether that's data aggregation or looking at supporting providers on their integration journey. Even if you're not integrating at the payer level, to be able to look at how you can best establish the ability to support providers and to care coordinate across those systems. I think many of these things can be focused on by states even if they're not merging at the policy level.

Laurie Hutcheson: Thank you. We're now going to move on to what New York has done using cross agency collaboration to develop new frameworks of support integration.

Trisha Schell-Guy: I'm Deputy Counsel at the New York State Office of Alcoholism and Substance Abuse Services. As you can see, we in New York, unlike Arizona, are still separated into separate agencies here. We have a Department of Health that oversees physical health and primary care and an Office of Mental Health that oversees mental health services. For those of you unfamiliar with New York State, we are one of the few states that have a separate executive level agency that oversees our substance use disorder and that is the Office of Alcoholism and Substance Abuse Services. So it makes us a little bit unique, and some might say it makes it a little bit more challenging when it comes to looking towards integration because like many states we were in our own silos. So for many, many years we were all very

protective over what each of our own agencies did and had to be thoughtful and really work together when it came to starting to integrate.

We're going to take a few slides and talk about why we began thinking more seriously about integration. Like I said, we were these autonomous agencies for many, many years, but we were being asked by a number of entities to start thinking about integration. We were being asked by providers. We were being asked by payers, and we were being asked by state leadership to take a close look at doing things differently and doing things better for a number of reasons. And to look at integration from a policy perspective, from a clinical perspective to provide better clinical care, and from a financial perspective. Like many states, our Medicaid budget was exploding and people were looking for ways to get that under control. So integration was one mechanism that provided an opportunity to take some control and achieve some of those goals.

We'll talk a little bit about the background on some of those strategies, the strategy behind integration, what we needed to do as state agencies to achieve that, how we needed to organize ourselves. You heard Tom in Arizona talk about leadership and buy-in at the top. That's really important. We'll talk about that in some of our strategies. Then talk about some of the actual models put forth as a result of the numerous initiatives in New York State that were already in play. So we had a lot of things going on when people said hey, New York, let's start integrating. We had a redesign of our Medicaid system that was taking place. We had DSRIP. On top of that came let's start the integration initiative. We'll end with some of the lessons learned as we implemented all these various projects.

So really what was it that moved us to start looking at integrating care? It was pretty obvious in 2011 and even before that, when I started getting involved in this project, which we were working in a really siloed system. Everybody knew that people had co-occurring physical health and behavioral health needs, yet their care was managed separately. You heard Tom talk about this also in Arizona. Payers were managing care separately. In our system back in 2011 from a Medicaid perspective physical health was carved into managed care, so plans were managing that, but behavioral health was primarily carved out of managed care. Those two systems were being managed separately from a payer perspective. They were being managed separately from a provider perspective. So that didn't really lead to coordination. It was very fragmented. They were also managed separately by agency oversight; the agencies didn't really talk to each other. The providers didn't really talk to each other. Everything was fragmented. Even the two behavioral health disciplines, the substance use disorder and mental health services, were fragmented from each other. We would work together a little bit but really not in a coordinated and cohesive manner to meet the needs of patients. So our patients would be seen in a mental health clinic and they would get some of their substance use disorder treatment there or they might be seen in the substance use disorder clinic and get some of their mental health services there, or they might be seen in both clinics and get services in both clinics. But the clinics really weren't talking to each other. The agencies weren't really talking to each other, and everything was really fragmented and costs were skyrocketing.

So the goal was let's improve the overall quality of care, let's treat the whole person in a more comprehensive manner, and let's try and save some dollars. When we started to look at some of the data, especially some of the data concerning the behavioral health population, it became very obvious to us that we needed to become more organized and become more effective and start to make some true efforts at integration. Our opioid deaths and overdose deaths were on the rise. Forty-two percent of significant depression in the United States remained untreated. Our New York State data showed that Medicaid members diagnosed with behavioral health accounted for 20.9% of the overall Medicaid population in New York State. The average length of stay for admission for behavioral health Medicaid

users was 30% longer than all other Medicaid populations, and the costs were really through the roof for Medicaid members with behavioral health diagnoses, 2.6 times higher than the overall Medicaid population.

The behavioral health population was spending a disproportionate amount of the total annual cost in New York State and they absolutely accounted for a disproportionate amount of the hospital visits in New York State. Essentially, we had a couple things going on. At this point, it was 2015. We began to start some integrated projects. We also began to start initiatives we called Care Management for All. Really that was where we started to move all populations into managed care. That included the behavioral health population. The statistics on this slide show you why that was really necessary: Behavioral health population accounted for 32% of primary care visits, 45.1% of ED visits, 60% of the total cost, and 53.5% of Medicaid admissions. We began to carve-in to managed care of behavioral health at the same time as we began various integration initiatives. The two started to move hand in hand, which was a good thing for New York State because at the same time as we were carving the services into Medicaid managed care, we were also beginning integration with the providers and to work together as state agencies. So it really was happening all together and all at the same time.

Our approach to behavioral health and physical health, or primary care integration, really has been an evolution. It did start before the managed care carve-in with some of what I would call the easier models, things that were easy to achieve. These are just multiple models we're going to go through. The first one is multiple licenses. Multiple licenses is pretty obvious. A single provider in our system. I'm talking about a provider of ambulatory or outpatient clinic services. Those were the easiest providers essentially for us to begin to integrate services with so that's really where we started. A single provider could apply to each of the agencies—the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Department of Health—for a license and get a license from one, two or three of us, and integrate those services at a given site, and provide multiple services at a site to an individual. The good part of that was an individual could come into one location and receive primary care services and mental health services at one location. The bad part of that is a provider is subject to regulatory oversight by multiple agencies and an individual has multiple providers they're going to see, multiple records. Staff is not necessarily integrated, not necessarily cross trained. So while the individual might have the convenience of being in one location, it's not necessarily fully integrated.

We evolved a little bit where we decided that it might be beneficial for a provider that had a single license to be able to offer a small amount of services that were otherwise under the authority of jurisdiction of one of the other agencies. We call this licensure threshold. What we allowed was providers that had clinic sites—again this is only clinic sites—and DOH licenses were permitted to offer some mental health services, limited amounts, no more than 10,000 or 30% of their annual visits at that site. So they couldn't go above that threshold. If they did they would have to get a license in the Office of Mental Health. Likewise, a clinic site that was licensed by the Office of Mental Health or by OASAS did not need to get a license from DOH; they could do some physical health or medical services up to 5% of their total visits and they didn't need to go and get a license from the DOH. Unfortunately at that time we here at OASAS took a more firm stand on OASAS SUD services and we did not anybody to provide any SUD services unless they obtained our license. That was back in 2008. Since then we have morphed a little bit. Keith will go into more detail.

Keith McCarthy: So as Trisha mentioned, when Andrew Cuomo first became governor of New York in January 2011 one of the first things he did was launch the Medicaid redesign team to “conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.” Early on the MRT

declared that our state structure for providing behavioral health services was fragmented and didn't promote integration in care. Overall the MRT Action Plan launched a series of innovative solutions designed to better manage care and reward providers to actually keep people healthy. More than 200 initiatives were created as a result of the MRT and they were advanced as budgetary items, statutory provisions, and regulatory administrative actions, all with the goal of changing the way healthcare is provided in New York as well as reimburse and manage to ensure that we are providing quality of care in the most efficient manner possible. Ultimately in April 2014 the Governor announced that the state had finalized terms and conditions with CMS for the DSRIP waiver to allow the state to reinvest \$8 billion in federal savings generated by MRT reforms into new innovative initiatives.

So after integrating via multiple licenses in the 2008 thresholds, things accelerated with the Governor's MRT efforts. One of the many MRT work groups formed was the Behavioral Health Reform Work Group. They started to dig heavily into the directive to really find ways of being more efficient. While the state's DOH and Office of Mental Health and OASAS services had already been discussing the topic for quite some time, among the short list of proposals advanced to the agencies to the MRT was facilitating co-located physical health, behavioral health, and even developmental disability services. Among the Behavioral Health Reform Work Group's final recommendations to the Governor was direction to the three agencies—DOH, OMH and OASAS—to review and revise our clinic licensing requirements to allow for co-licensure, reduction of duplicative or contradictory requirements, and to provide incentives to increase co-located behavioral health and physical health services. So between the agencies the staff began to discuss how best to integrate clinic services, whether it be through MOU regulations, develop a new model or whatever else we can think of.

So the enacted state budget in April 2012 included legislation that authorized DOH, OMH and OASAS to integrate physical and behavioral health services through an easing of the administrative approval and oversight processes, as well as improving opportunities for accessibility and coordination. To further these ends, the staff of the three agencies began comparing each other's existing clinic regulations and standards, and we called ourselves the Implementation Work Group. We met every Friday at noon for many, many months—actually a few years—to address each of our clinical standards, staffing requirements, physical plant standards, and application and review processes. Ultimately the interagency work group decided to utilize each agency's existing clinic regulations as we each licensed clinics within our agencies, and standards, and we began to work to develop a set of what we called supplemental standards to be followed for what you would consider the add-on or integrated services to be brought into those existing clinic sites. The team decided to pursue this initiative as a pilot project that we called the Integrated Licensure Pilot Project, with each agency nominating existing license providers for participation. In total, we had seven providers and 15 clinic sites participate in the pilot.

Through the Integrated Licensure Project, the state team worked together on the weekly calls over many months to develop a single set of standards for integration, an abbreviated application with the ability to be processed in a more expedited manner than a traditional licensure application, and a single survey process, all to be followed whether the clinic site was licensed by OMH, OASAS or DOH. We also promoted the integration of patient records by allowing providers to develop their own rather than prescribing an integrated record for all to use. We viewed this project as much for us as the state agencies to learn about the ideas of the providers as for them to test out ideas that we would simply impose upon them. We also developed new billing rates and codes, which for the pilot included a 5% bump to their existing reimbursement. In all, we did our best to reduce the regulatory burden through the designation of one lead or host state oversight agency, the agency from which the site already had a license. So although an agency may have multiple licenses as an organization, they would only have one survey, which would be completed by an interagency team. Obviously this was huge for providers rather

than having be subject to three different state inspection processes. Programs were expected to adhere to the operating standards of the host agency and the applicable supplemental standards for the additional services authorized at the site, the agency or agencies from which the site now sought approval.

To facilitate the survey process during the pilot, a resource notebook was compiled for the surveyors to use and included a background document on the demo, the supplemental standards document, necessary survey instruments, pertinent regulations, and a list of required documents that each state agency requests for review from the providers when they show up for an inspection.

In 2014 the Interagency Work Group was given a charge by the Governor's Office to expand our integration activities beyond the pilot project. Therefore, utilizing the principles that guided the project, we developed a regulatory proposal to do the following: allow a provider to deliver the desired range of cross-agency clinic services at a single site under a single license; require the provider to possess licenses within their network or organization from at least two of the three participating sites; have the site's current license serve as a host; and authorize the desired add-on services via the state agency currently with primary oversight responsibility for such services. Though the last point was modified prior to finalizing, we witnessed a culmination of our 4-year effort to integrate physical and behavioral health services in clinic settings across the state on January 1, 2015, with the enactment of regulations.

A big achievement in the promulgation of the regs is the fact that they appear identically within each state agency's regulatory set. So whether you're a DOH provider looking at the DOH regulations, an OMH provider looking at the OMH regulations or an OASAS provider looking at the OASAS regulations, you're all looking at the exact same language when it comes to delivering integrated outpatient services in your clinic setting.

While we created a single application since DOH already possessed the advantage of an electronic certificate of need application system, they have providers apply through that. However, DOH requires that the applicant include the jointly developed integrated outpatient services application within that electronic CON filing. For OMH and OASAS providers, we have a shared link on our respective websites to the IOS application, and when a provider completes the application and has submitted the application, it is simultaneously sent to all three state agencies. However, it is the host agency that is ultimately responsible for review and processing of the application, though in the spirit of collaboration we do consult with each other prior to issuing any approval of the application. We feel this isn't just to make sure all agencies are on board but to make sure we create like processes and broaden the knowledge base of what it is we're trying to do via integration. IOS providers must meet the standards promulgated in our respective regulatory sets. For the DOH licensed previous it's part 404 of Title 10. For OMH, its part 559 and OASAS part 825, all of Title 14 of New York Code Rules and Regulations.

After only a few months of being promulgated, the IOS regs ended up playing a pretty prominent role within our district initiative in promoting community-level collaborations and focusing on system reform. With a 5-year goal of a 25% reduction in avoidable hospital use, the most desired project proposed under DSRIP was the integration of primary care and behavioral health services. Here in New York it's Project 3.a.i. In fact, all 25 PPSs identified this as a desired project. However, since the IOS regs require that the agency seeking to integrate possess the multiple licenses within their organization, a barrier for some to pursuing Project 3.a.i. was that many providers only possessed once such license. In essence, they were either only an OMH, DOH or OASAS provider with no prior experience within the organization of the other services to be offered. So to facilitate the integration of primary care and behavioral health services for purposes of project 3.a.i., the commissioners of the three state agencies utilized their joint regulatory waiver authority to develop mechanisms to allow such providers to

likewise benefit under DSRIP. In short, our interagency team came up with the idea of raising the licensure threshold across the board to 49% of the provider's total annual visits while ensuring quality care and patient safety through the incorporation of certain sections of the now-established IOS regs. To date we have 77 clinic sites approved for integration under the IOS regulatory construct, with an additional 33 sites approved under what we call the DSRIP 3.a.i. waiver model.

Trisha Schell-Guy: I want to add that OASAS agreed to allow substance use disorder, more so in DSRIP, which was big for us.

Keith McCarthy: Now to Shaymaa.

Shaymaa Mousa: Where do we go next? With these various initiatives and integration models, the shifts in reimbursement policies and emerging technologies, the pace of healthcare innovation has outpaced the ability of New York's regulatory structure to adapt. To address these issues and get feedback on what's working and what isn't, New York State convened stakeholders in a regulatory modernization initiative as well as an integrated billing work group to look into the reimbursement issues specifically.

In order to facilitate an environment that ensures access to care and promotes patient safety and reducing costs, New York State is holding a series of policy work groups with providers, payers and consumers to examine existing laws, regulations, and policies and recommend appropriate changes.

One of those work groups examines how to best facilitate the integration of primary care and behavioral health services. Some of the barriers identified by this work group include the various rules regarding which patient providers of a particular license type can serve and the volume of additional services that can be provided, and varying licensure and surveillance requirements for the physical plan standards or treatment plans, depending on what kind of provider you are. Some recommendations from the work group included creating a simple and flexible model for integrating licensure, which would allow providers to add services without needing to obtain another license, and resolving issues with reimbursement.

Reimbursement is a topic that comes up frequently. The need to incentivize services integration by making it easier to receive reimbursements is something we hear often. The state convened work groups to address the many barriers associated with billing and payment, including many providers who have already integrated services and payers to share the barriers and issues they're having. Some of the barriers raised include issues with obtaining contracts from health plans for other services. We heard, for example, that a clinic licensed to provide mental health services and looking to add primary care services would be told by the plans that they already have enough primary care providers in that area. The difference being using the term physical health versus primary care, which is defined in the Medicaid managed care contracts, and the need to meet those requirements in order to be considered a clinical primary care provider. The different approaches to credentialing based on provider types or behavioral health providers will often be credentialed by a plan on the facility level versus a medical setting where plans credentialed individual providers.

Negotiating rates for a new service is another concern providers have, especially smaller and more rural providers where the services are needed but they don't necessarily have a large volume and scale to negotiate with plans. We have some plans in New York that contract with behavioral health organizations to manage those benefits and that in turn causes payment issues for behavioral health providers looking to integrate primary care. And when you have more than one service at a site provided by different providers, which practitioner ends up on the claim?

New license types or new models we're looking at: In the behavioral health setting we're looking at integrating some of our crisis services and behavioral health inpatient settings. One of the recommendations that came out of ROI was creating a simpler model for healthcare integration and this is something we're currently working on. After two years of assessing the success or shortcomings of the new licensure category or model, DOH, OMH and OASAS will evaluate whether barriers to integration still exist and should there still be barriers that we can explore additional changes, including the possibility of creating a new license type that would allow an extensive array of services to be provided by clinics with oversight from a single state agency.

Lessons learned:

- Buy-in is essential, especially at the top. We have the Governor's Office supporting these changes, commissioners, etc. Having the right people in the discussion is important. A lot of times these topics breach many areas and you need to pull in individuals from licensure, surveillance, architecture, Medicaid. So it's important to get input and know when to involve key players.
- Reviewing what you can and can't do from a legal perspective is essential. Of course changes in regulations or the introduction of a departmental bill is always an option, but you need to factor that into the decision-making process. While you may find many providers that believe in integration and think it would benefit their patients, there probably won't be anyone integrating services or continuing to provide those additional services if they're not going to get paid. There really won't be any long-term success without working out the billing and reimbursement issues.
- There's usually going to be something that comes up that you hadn't predicted, thought of or planned for. So it's a good idea to start off with a pilot program to get feedback and learn from those providers' experiences before going full fledged.
- Finally, the ability to be flexible and accommodate different things that come up along the way is really important if you want to be successful in these types of initiatives.

Laurie Hutcheson: Thank you Keith, Trisha and Shaymaa. Following are some questions we received.

*On slide 37, was there an overall mental health diagnosis for the 53.5% of Medicaid admissions?*

Shaymaa Mousa: No. The diagnosis there was behavioral health, so that would be both mental health and SUD diagnoses together combined.

Laurie Hutcheson: *Does New York plan to integrate OMH and OASAS in the future?*

Shaymaa Mousa: There was four years ago when our governor was elected a stage commission appointed to actually look into that. But after the report was issued, it was determined that now or then was not the right time for that. So while it's sort of out there, there are no plans at this time to do that.

Laurie Hutcheson: *After implementation of the new processes, was there a decrease in the utilization of services listed in slide 37?*

Shaymaa Mousa: We're in the process of gathering data and we have lots of initiatives going on. So while we do have reductions in emergency room visits overall and admissions, whether or not we can attribute those all to integration efforts is difficult for us to say at this point.

Keith McCarthy: Yeah, there's so much going on in DSRIP and with the transition here in New York in particular of our behavioral health populations into Medicaid managed care that it is kind of tough at the moment to try to figure out which has had what impacts.

Shaymaa Mousa: So yes there are reductions, but what we attribute them to is a little bit more difficult for us to say.

Laurie Hutcheson: *Did the issue of same-day copays for patients come up? We see patients have two copays when integrated care is delivered in integrated settings and wonder if this is an issue in New York.*

Keith McCarthy: Actually it is. Shaymaa touched on the work of the RMI work group on behavioral health integration and that was actually one of the issues that had come up during those discussions was that providers—I'm sorry, I'm confusing my work groups. Actually we heard that more on the tele-health side that clients are getting double hit for copays. I don't believe we have heard that on the integration side.

Shaymaa Mousa: The way our providers bill in integration in outpatient settings now, we bill under the ATG, ambulatory payment billing methodology, so it all goes in as one claim. One claim with different CPT and HCPC codes on the claim, then it all sort of bundles together for one payment. So we hadn't really seen that issue come up. On the commercial side I can't really speak to that. We haven't heard that. But I think it's a function of the way the claim is.

Laurie Hutcheson: *How did you deal with resistance that comes with integration?*

Keith McCarthy: Put it this way, when the Governor's Office tells you to do something it's tough to be resistant. Our weekly work group that met every Friday helped to create a consistency in the group that was coming to the table to discuss it, and we all knew what our end game was. It's safe to say, though, that even within our respective agencies, when we had to go outside of the work group to help get insight, as I think with any state and agency, you do have a siloed mentality. But I think because our work group was large enough and had so many aspects of our respective state agencies involved that we were able to really work through those.

Trisha Schell-Guy: One thing I would add that you need is you really need a point person, at least in a state like ours that's large where you have individual agencies, it's important to have point people that remain consistent over time so they can recall the history and remember what's happened. At least I find that valuable.

Keith McCarthy: Very much.

Laurie Hutcheson: *How did Arizona limit the scope of outside expertise when improving managed care contracts?*

Tom Betlach: Can you say more about what that means?

Kitty Purington: The question is *How did Arizona limit the scope of outside expertise in supporting improvements to Medicaid managed care contracting details?* We can ask the questioner for more detail.

Tom Betlach: I'm looking for more detail on that.

Laurie Hutcheson: While we're waiting, next question: *Is Medicaid now considered the behavioral health expert following the merger?*

Tom Betlach: In Arizona it is. That's where all the expertise lives. Clearly we have resources beyond Medicaid that we administer like the SAMHSA grants and other funding streams. But the expertise all now lives within the organization.

Laurie Hutcheson: *Regarding copays, if it's under one claim, does the organization/client/providers only get reimbursed for one service when the patient receives more than one service?*

Trisha Schell-Guy: No, they don't. The way the billing works is there's one claim but on that claim are multiple services. There's a base rate and attached to that base rate are multiple procedures. Each procedure has a weight that builds against the base rate and they all bundle up into one payment.

Laurie Hutcheson: We have more information on the question on limiting the scope of outside expertise, for Arizona. Managed care can be controversial. The question was: *How do you separate politics from practical help?*

Tom Betlach: Arizona has the advantage of only having managed care. We created the Medicaid program. Arizona was the last state in. It came in under a mandatory managed care model through an 1115 waiver. So our whole model and delivery system is built on the framework of managed care and always has been. We have always looked at opportunities to improve that but the debate around managed care in Arizona has not existed.

Laurie Hutcheson: Another question for Tom: *Does CMS provide enhanced match for merging the two data systems in Arizona?*

Tom Betlach: The way it works was the sister state agency supported its data system infrastructure. They reviewed as the managed care organization so they got traditional federal matching for services, only brought it over here. We got whatever the administrative match would be. So for those systems in which you're doing design development you get the 90%, for some implementation you get 75% and for some you get 50%. So there was no special match related to the merger. We just leveraged whatever typical match is allowed for admin.

Laurie Hutcheson: Also for Tom: *If the behavioral health expertise is now in Arizona Medicare, how do you integrate services among your local behavioral health authorities who may also serve the indigent populations?*

Tom Betlach: All that is largely done through the managed care organization. So if you're serving the indigent population in all likelihood in Arizona it's being done through the SAMHSA grants, which are administered through our managed care organizations. There may be some local money available but very little. The vast majority of it either flows through the state or through the federal grants and making its way through the managed care organizations.

Laurie Hutcheson: For New York: *What have been the health impacts of integration?*

Trisha Schell-Guy: We're still in the process of gathering all that data and information. We are working on that. I don't have those statistics at this point. Shaymaa?

Shaymaa Mousa: Also as part of DSRIP, some of these projects, integration is a big part of DSRIP as well with the reduction of unnecessary ED visits. So there's so many things going on at the same time, but we are still in the process of collecting data, and we don't have those kinds of numbers.

Trisha Schell-Guy: I don't have the numbers. One thing we're trying to look at is impacting primary care. One goal is to make sure people are connected to primary care and there's actually more primary care services going on, reductions in ER visits, better healthcare, but we just don't have that information.

Laurie Hutcheson: For Tom: *Can Arizona speak a bit more on how they wove funding for SAMHSA grants into the managed care contracts?*

Tom Betlach: We placed funding in there. There are SAMHSA requirements that are included in the contract and in addition to SAMHSA dollars there's funding from the state for housing and for state-only services, non-Title 19 services for individuals with serious mental illness. So it's all flowed in through contractual language with the managed care organizations and then the managed care organizations report back out on some of the information that we need to forward to SAMHSA.

Laurie Hutcheson: We're out of time for questions. I want to briefly recap some takeaways from our presenters:

- Leadership can set the tone to get work done across agencies. We heard in both states examples of how important buy-in is from agency leadership, both at the outset and ongoing, and how important it is to dedicate staff to focusing on the initiative and to really make the collaborations work.
- We also heard that stakeholders are experts in pinpointing what is preventing integrated care. There's no success if providers can't get paid. Providers and other stakeholders often know so clearly what the issues are and can be key in helping generate effective solutions. It's really important to engage them early and often, and to support providers as they progress towards integration.
- It's also critical to celebrate successes as you go, to share lessons learned, and to provide training and cross training across agencies. In both states we heard how ongoing sharing of information and lessons learned is one of the best ways to enable building on your successes.
- There can be early wins but not too many quick fixes early on. It really takes a detailed, systematic process. Processing lessons learned carefully is critical in order to build effectively on what has worked.

I hope you agree we've heard a lot in this short time of really great information and have received important guidance from presenters today that will hopefully help all listeners in the future to address these administrative and regulatory challenges in your state.

An evaluation will appear in a popup on your screen. This is the fourth webinar and the last. Refer to the IAP website for upcoming NDS resources.

Thanks to all our presenters and listeners.