

**Medicaid Innovation Accelerator Program (IAP)**  
**Physical and Mental Health Integration Webinar — Planning a State Approach for Physical and Mental Health Integration, Key Steps and Considerations**  
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Lyndsay Sanborn: [Intro]

Karen VanLandeghem (KVL): Good afternoon, everyone, and again, welcome to the Medicaid Innovation Accelerator Program's Physical and Mental Health Integration Webinar — Planning a State Approach for Physical and Mental Health Integration, Key Steps and Considerations. For our agenda for today, you're going to hear:

- An overview of the Medicaid Innovation Accelerator Program PMH initiative;
- An overview of planning and developing a PMH integration initiative;
- And insights from two participating states, New Jersey and Washington, who both participated in Cohort 1.

We would like this webinar to be very interactive. So if you have any questions, please chat those questions into your chat box. Between the two state presentations, we'll have a few minutes after each state presentation for you to ask questions, again, using the chat feature and the chat box function. Then, at the end of the presentation, we'll be hearing and having some interactive discussion facilitated by my co-facilitator, Colette Croze.

Our presenters for today are:

- David Shillcutt, who's with the Disabled and Elderly Health Programs Group at the Center for Medicaid and CHIP Services at the Centers for Medicare and Medicaid Services;
- Kitty Purington, who's a senior program director at NASHP;
- Steve Tunney, a chief with the Behavioral Health New Jersey Department of Human Services, Division of Medical Assistance and Health Services. He'll talk about the work in New Jersey;
- Colette Rush, who's a behavioral health integration and clinical consultant, new grants and programs, with Washington state's Health Care Authority.

I'm now going to turn this over to David Shillcutt.

David Shillcutt (DS): Thanks. Today, I really appreciate everybody joining this. We'll be talking about some of the lessons learned from work that we've done through the Innovation Accelerator Program over the course of the past year, approximately, with nine different states to work on furthering integration of

physical and mental healthcare needs. We had two different groups of states. There was an intensive group that worked with individual coaching over the course of the full 12 months or so, and then another group that we called the Integration Strategies Workgroup that had a little bit lighter touch. All of them were focused on these topics, administrative alignment, payment and delivery system reform, and quality measures, including other issues. We're really excited and energized by some of the progress that they made. We also feel like there's a lot learned from some of the challenges they encountered and some of the creative solutions and strategies that they've come up with to address these needs.

We've put together this series of National Dissemination Webinars to try to share some of those lessons learned so that we can leverage that knowledge and experiences gained by our participating states for other states who are interested in working to enhance the integration of mental and physical healthcare service.

Today, we'll be talking about some of the main considerations that states should think about when they're planning and developing a PMH integration initiative. Really appreciate the participation by New Jersey and Washington. They've got a lot of great messages and really appreciate the time they've put into doing the work and to packaging and sharing those lessons learned with you.

On this slide, you can see the list of the states that participated. We find that state-to-state sharing is often really helpful and so, I encourage you to reach out to participants from those states for further information about what they're doing. With that, I'll turn it over to Kitty.

Kitty Purington (KP): Great. Thanks very much. Thanks, David, thank you, Karen, and thanks to all of you on the line for joining us. I'm just going to say a few brief words about some of the common themes that have emerged from our work with a total of nine states that participated in various levels in the IAP physical and mental health integration track. So these states are in very different places in terms of what they have been trying to accomplish, through what policy levers, and what stage of implementation they are at in their work. But even given this diversity, we still found that states were encountering and discussing with us very similar challenges and were often having the same internal discussions and posing similar questions to us as they worked through their state efforts to build more integrated systems of care. So I just wanted to share these with you as a way of framing the discussion that follows and we'll hear from both New Jersey and Washington, who are going to be touching on some of these themes.

First, many of the states that we've worked with have had questions about what is the definition or the model or the major features of integrated care and what is it exactly that they are trying to promote and how do they communicate this to their key stakeholders? As we know, integrated care can really mean a lot of different things for different people and I think what we have heard in our work with states, what states have been talking about, is that how it looks can and should be very dependent on what the needs of the target population are, where that population is receiving care, and what is going to be needed to support those individuals in receiving and support their providers in delivering more integrated and more effective healthcare. So it's a very state-specific and population-specific discussion in terms of shaping those definitions and models. There are many different tools and levers and models of integrated care out there, from screening and brief intervention to collaborative care that targets depression in primary care to embedding primary care practitioners within community health clinics.

We've also learned that that can be very worthwhile for states to spend some time preferably with their stakeholders, thinking about what this means for their state based on their state goals and the healthcare needs of their particular population. States may be interested in supporting a specific model, such as

SBIRT, or they may be interested in building more of a broad foundation that can support multiple models. So again, we'll hear a bit more about this from the state presentations and also welcome your thoughts and questions about this as well.

Another theme that came up in our discussions with states and in their internal discussions is that state policy makers are typically using data and some other kind of available information to really understand the needs of the population and the resources and opportunities available to address those needs, both before they get started and during the implementation phase. I think it's an iterative process, from what we've seen, and the information and the data varies from state to state. It may involve a gap analysis or assessment tool that is implemented with providers to determine what kind of infrastructure they have in place in their primary care networks. For integrated care delivery, states have also inventoried internal state programs internally to see where the alignment and perhaps some critical mass to moving forward on integrated care. Then, there are also very widely divergent capacity in terms of data analytics, external resources, and research available to better understand the cost drivers of the Medicaid population and how those needs can be better addressed through integrated care interventions.

So I think we'll hear a bit about this again during our presentations, but much of the takeaway is leverage what you have available and find out as much as you can and to have that be, as I say, an integrative process.

Another strong theme we heard from states who are leading this work was really the importance of working across state silos. Medicaid and behavioral health leadership certainly are key partners, but also internal data analytics capacity, licensing, managed care oversight, other leaders who represent critical state oversight functions can really be vital to the conversation. One of the themes we will be exploring in depth in a future webinar on resources has to do with administrative alignment and how states can themselves take a more integrated approach to administration to better support delivery system reform. I think we've seen that this can be reflected early on in how states structure this work across state silos.

Finally, the importance of engaging stakeholders has been a recurring theme with the states that we've engaged them in this work and, again, takes a number of forms. Some states have really leveraged external committees and resources to help them gather in-depth feedback and even structures and guidance. Other states have been very deliberate in populating committees and workgroups with key stakeholders to ensure active involvement. And this kind of engagement not only improves the end result, we're also seeing it's an extremely valuable tool in identifying and addressing specific barriers and preparing providers and systems for what can be a significant culture change, and also in creating an informed group of consumers or enrollees who will understand the benefits of accessing integrated services and will come to expect them.

That's just a very brief outline of some of the major themes that we have seen in our work with states on their physical and mental health integration efforts. New Jersey and Washington will be touching on some of these overarching themes in their presentations. Again, we really encourage you, folks on the call, to raise any questions and similar issues in the chat feature that you may be thinking about as well. So thanks and I am going to turn this back over to Karen.

KVL: Thanks, Kitty. So I'm now going to turn it to Steve Tunney, who, again is chief behavioral health with New Jersey Department of Human Services at their Division of Medical Assistance and Health Services. Steve's going to talk about the work in New Jersey. As Kitty has mentioned, if you have questions for Steve, just please type those into the chat box function. We'll be monitoring that throughout his presentation

and we'll have time at the end of his presentation for Q&A. I also want to give everyone a heads up that we'll also have a polling question after the Q&A period. So please look for that. With that, I'm going to turn this over to Steve. Steve?

Steve Tunney (ST): Thank you. Okay. So New Jersey's Division for Physical and Mental Health Integration began to expand the network of integrated providers across our continuum of care. The target was our clients with serious mental illness and substance use disorder populations and one of our big goals was just to fully integrate managed care coverage for this population. We also wanted to expand managed care's role in managing the non-traditional services. It was determined that a lot of the services that came out of our stakeholder meetings were things such as housing and social service-type issues. That was something new to our managed care plans. We had just begun doing that to our MLTSS contract. So we're looking to expand on them hiring maybe housing experts and things of that nature.

The big drivers for New Jersey for this change, the first one came about during the governor's fiscal year 2015 budget address where we called on the Rutgers Biomedical and Health Sciences to join with others to devise a program to innovate and improve healthcare delivery across Medicaid and New Jersey family care with a focus on super utilizers. This came out of a study that was in 2013, when New Jersey Medicaid spent approximately \$9.4 billion in direct patient care for 1.6 million recipients. 1% of those recipients accounted for 28% of the total spend and 86% of the individuals in that top 1% had a mental health or a substance abuse diagnosis. 33% fell into the category that were considered to be severely mentally ill.

In calendar year 2014, Rutgers' group started a quantitative analysis of claims data and outreach to Medicaid stakeholders. They reviewed research for potential strategies to improve care and decrease the cost of these super utilizers. They found that the vast majority of the super utilizers also maintained spending persistence and they were in that top 1% year-to-year. They reached out. They initiated a major part of our stakeholder input. They included private research groups, community mental health providers, individuals with SMI, insurers, physical health providers, provider associations, and, again, they brought in social service agencies.

One of the other big drivers that was fairly well known to us for a while was the poor health outcomes for behavioral health clients. They have a decreased life expectancy, approximately 25 years, and many of the factors that are with metabolic syndrome are modifiable. So a lot of our initial work with our independent clinics especially was to work on diet control, cholesterol, diabetes, things of that nature. Data used to drive the changes in analysis and recommendations for the high utilizers, there was five areas that were recommended by the Rutgers team to advance:

The integration of behavioral health and physical health was the primary one. That's the one that we focused on most. But the remaining four are pretty much tied into the same population. Those with persistently high cost to coordinate the social service and public health initiatives and to adopt best clinical practices. This is something that we were trying to tie in with health performance. So we would do a pay-for-performance practice. And to strengthen infrastructure and accountability.

The data that was used to drive the change, data support efforts to pursue integrated care, there was lots of data in our initial runs that were done to our shared data warehouse, which was all claims related. You can see there was high rehospitalization rates, reutilization of emergency room, poly-pharmacy, all the standard things that were costing a large amount of money. That was the information used to identify the super utilizers. We also knew that there was a large percentage of our prison reentry population that was coming in. The Department of Corrections had told us that they had approximately 80% of non-

compliance with scheduled appointments after release. So they were looking for some help to try and get their clients involved in addressing their substance abuse and physical health needs. They also showed an increased mortality within the first 30 days of release. There were very high numbers, I don't know the percentage, of drug overdoses for that population.

And then, in New Jersey, we have a substance abuse monitoring system, which shows statewide utilization of all substance abuse services. All providers are expected to put their data into the system, whether Medicaid is the payer, the state dollar, whatever it would be. So we got a lot of good information on that.

The other part, the Rutgers Biomedical and Health Sciences team did a high level interstate research across the country to see what other states were doing and they initiated a value-based payment, PMH integration resources. That was taken over by another team and they're working currently on accountable care organizations and other areas and there's also several pilots that are going on for the value-based payment.

The initial planning came from our core team. We were meeting biweekly. It was mostly the Department of Human Services and that includes the Division of Mental Health and Addiction Services and the Division of Medical Assistance and Health Services, which is Medicaid. We also had an office of Business Intelligence that was running all the reports that we needed through our shared data warehouse and other resources that they had. And we had a director of behavioral health, which was a new title that was put in at department level and her job was to coordinate the services between the different divisions.

Our leadership primarily came from the Commissioner of Human Services and under her was the deputy commissioner and the deputy commissioner really took the reins and was the person that was driving most of the committee meetings. We needed somebody with a lot of authority that had contacts with the governor's office and some other directors, and that was a big plus to help us move things along. And there was also a director of behavioral health who worked under her and she was the one that was developing a lot of the individual policies that helped us with the integration of care.

So on the Medicaid side, we did monthly updates to the director and they also have a new position that was created - director of policy development. That was necessary because a lot of the things that we were doing had to be tied into regulations that were being promulgated as well as with the comprehensive waiver and other services that the governor and the commissioner were pushing for New Jersey Medicaid.

Our key stakeholders were independent clinics. The primary mental health providers in New Jersey are primarily independent clinics. They were interested in integrated care from the very get-go and they had a lot of experience in reaching out. They were seeking integration. They had early partnerships with federally qualified health centers. They ran into a big licensing issue, which involved shared space where the FQHCs were not allowed to have their clients for their mental health and the physical health in the same space under our licensing requirements. So they were actually working on having the FQHCs come out to their independent clinics and provide the primary care services there. The FQHCs have a strong desire to provide behavioral health. Again, we had some licensing issues because it required dual licensing. There was a scope of work issue. There was a lot of confusion about whether or not their scope of work did or did not include behavioral health. They did offer prime locations. This was very important throughout the state. We had FQHCs located in most of the really urban areas and they had a prospective payment system, which was based on their encounters, which made it easier to find providers.

The hospital networks, they wanted to make a move into the community. They have a lot of resources. They have the statewide urban presence. Again, we ran into a little bit of a licensing issue. They're licensed by our department of health if they provided services a community that would require licensing by the Department of Human Services and there was a billing issue that we never encountered. We were working on a system to have their revenue codes pay off for the procedure codes so we could kind of unify our community behavioral health systems. It was a lot of programming that would be involved in that and we were in the process of getting a new MMIS system. So after 2018, that's going to become one of our biggest priorities and we'll really start working with the hospital providers who have shown great interest in being a provider and, like I said, have most of the resources that will be required. It should be a fairly easy transition. It's just getting the ability to pay them based off of the community network rates that we established.

The managed care plans, we're bringing them. They have a large network of providers and they have expertise in the coordination of care. We wanted to take advantage of that. We've been increasing their participation with subgroups, like our dual SMP programs and MLTSS and our developmentally delayed populations, where we've made all those populations fully integrated with their behavioral health and their physical health. The rest of New Jersey, the behavioral health is all carved out fee for service.

The lessons that we learned, we had initially lots of people that were very interested. We had large meetings and over time, that began to thin out. It was the same people coming all the time. So we required commitment. We had to make sure that those people that were willing to participate had things assigned to them and we kept them active to try keeping them coming back to the meetings. This was difficult when you're dealing with other departments because they had their own sense of priorities and we had ours. We had to anticipate these early, make sure that we gathered necessary data that we could start our meetings with the data to support what we were looking to do and we wanted to maintain momentum. We had a big push initially for electronic health records. There was a little bit of resistance out in the community, mostly, I guess, financial, but it's been a little bit slow coming. Again, New Jersey Medicaid, we have an office that's working with our providers and promoting electronic health records across the state. Once we have that, this came out of our early behavioral health home work, it makes life so much easier for the physical health providers to communicate with the mental health providers when they are not in a shared location.

Planning and development of the integration approach, we had to anticipate needs, have the right people in the room. These were generally the ones that are deputy commissioner meetings, where we brought in other people from the Department of Corrections, Department of Health, or housing groups, people of that nature. We wanted to also maintain stakeholder support and assistance and we had to consider dedicated physicians to coordinate and direct those efforts. Just running these meetings because of the amount of information that we were doing and the timeline we were trying to accomplish them within really required a full-time person to work on.

Engaging the stakeholders, we maintain regular contact with those affected by potential change. The initial stakeholder group meetings, we had a lot of active participation. People had lots of great ideas, but not all stakeholders share common goals. They obviously are interested in the things that they're going to benefit from. We had to make sure that we listened as well as proposed. We were used to dictating to the stakeholders what it was that we were looking for through Medicaid services. So that was important. We held those formal and informal meetings. Sometimes, it was better to separate out some of those key stakeholder groups and just deal with them directly, particularly the FQHCs. Again, we wanted to maintain engagement.

Unanticipated issues and barriers were competing priorities. This was a good thing that had kind of a negative effect. But when we had the expansion of SUD services and we started covering them under New Jersey Medicaid, there was a lot of work that came into play. All the codes, all the regulations had to be promulgated. So a lot of the people that were involved in the integration of care kind of got sidetracked off on working on those other projects.

The licensing by multiple departments I'll get into a little bit later, but that was another major issue that came up, and then budgetary concerns.

So everything we did had to be budget neutral, and that makes it difficult when you're trying to come up with new ideas. So I'll take this moment to go to one of the big areas that came out of the Rutgers stakeholder forums resulted in another university, Seton Hall University, which was commissioned to develop strategies to create a single licensing entity working with integrated licensing standards to promote fully integrated care. Most of our provider stakeholders complain vigorously about the competing licensing standards and being licensed by two different departments that had different expectations and if they would change things to meet one department, then the other one would come in with their licensing people and tell them they wanted it another way.

So this group is working under a grant from the Nicholson Foundation, which is a private organization that — they're working with the governor's office to make sure that they can get the regulations and everything that's involved all going in the same direction.

What would we find helpful? One of the biggest things was reviewing activities from other states. We had a lot of input from Indiana. We had lots of ideas about SQHs, but we had a lot of difficulty figuring out how we were going to pay them. All of our behavioral health services right now is working on paying for individual psychotherapy-type services. There's a lot of interest in then providing group therapy. So they had to figure out a way that we could work around the encounter rate, and that's one of the areas that we were looking to other states.

The hub and spoke model is another big one that we're using right now for children's behavioral health. There's a big shortage of psychiatrists, and children's psychiatrists are even rarer. So we have them in some university settings where emergency rooms and private practice physicians across the state, if they have a child with developing behavioral health issues can call in to those universities and they can offer suggestions to the providers and they also, if it's really a deep end kid, they can take those services on and then they guarantee to see the person, the client, within 48 hours.

Resources, what was helpful, value-based payment. This was an area where there's lots of different things out there. We just had to find what was important in New Jersey. Mostly, 95% of our population is in our managed care plan. So, as I said, there was a separate group that was kind of branched off that worked on determining value-based payments that they're trying to put into our managed care contract. Behavioral health integration primary care was just an implication for the payment reform that was a lot of good ideas on figuring out ways that we could pay for those type of services.

Our current next steps are planning and implementation. As I said, we are actually making very good progress with the Seton Hall University law organization, with the reorganization of licensing into a single licensing authority. The governor's probably going to call for a reorganization of part of what's in our division of mental health. We'll shift over to licensing and it'll just be one integrated Office of Licensing.

The realignment and focusing of statutes and regulations is something that they will do through the governor's office. FQHC provision of limited behavioral health services for integration of care, we are working with them now to determine the codes and the billing. Like I said, right now, they currently can provide family therapy, individual therapy. They can do limited substance abuse. They can't do methadone, but they can do other areas.

We had the expansion of our hub and spoke model I told you about earlier, for the children's behavioral health. That's now going statewide. That was primarily in the southern part of our state. We expanded our Department of Corrections prison referral to behavioral health homes. Our behavioral health homes are limited throughout the state, but the Department of Corrections actually makes referrals to our office. We determine where the person lives and we make contact with those behavioral homes who reach out to the prisoners before they're actually released, set up the appointment, and our goal there is to try and cut down on that 80% of the people leaving and never seeing a physician.

Everybody that has a substance abuse issue with alcohol has been leaving with injections and they wanted to make sure that they were getting the follow-up care that went with that. And our comprehensive waiver, there were some 1115 changes that we had to make to make sure that they were in alignment with the integration efforts that were doing. And again, the expansion of the electronic medical record usage.

Now, I'm at the Q&A. I forget who I was supposed to turn it over to. Karen?

KVL: Yeah. Thank you so much, Steve. That was a great presentation and we actually have several questions in the chat box. Just a reminder to everyone, if you have a question, please type it in the chat box. For our first question, if you could just expand a little bit more on what did New Jersey do to identify your initial list of priorities? So priorities for this initiative.

ST: What we did to identify the initial list of priorities was, like I said, pretty much we went through all of our stakeholder findings. They reached out to a significant number. There was — they fed them through all three sections of our state, the north central and southern part. There were 75 or more participants in each of the groups and there were lots of ideas. We took those ideas and those were pretty much the areas. There seemed to be a common theme. Everybody almost unanimously was in favor of integration of care. It was just a question of how we were going to do it. It was — so we took a lot of those ideas and that was probably our initial starting point. The taskforce from Rutgers actually spelled out most of the things that were raised by those groups. So it was actually a pretty easy way for us to get started. We just took the information that they had provided.

KVL: Great. Thanks. Our second question is two-part and it's regarding community mental health centers. So the first part of the question is, was billing the challenge for the community mental health centers? Then, the second part is, were they comfortable with the MMIS system?

ST: Our community mental health centers, which we call independent clinics, have extensive experience billing with New Jersey Medicaid already. What the governor did was he put a lot of money. They raised rates significantly to help cover the cost of these services. There was such a shortage of finding providers and we did a couple of innovative ways where we were allowing the clinics to bill — individually, we carved out the services for the psychiatrists from the bundled rates so that they could help offset those costs of paying for medical directors. So they moved along pretty quickly.

The independent clinic providers that did substance abuse services were primarily paid state-only dollar. They were paid off of a contract. That's a group that we're still nursing along. They aren't used to billing. They weren't familiar with the codes and the edits and all the other services, but I'm sure they'll be fine. So they're happy, for the most part, with the rates that they're receiving. So they're out actively expanding services and reaching back to us with suggestions and still actively participating as a stakeholder.

KVL: Okay. Thanks. Then, our next question is several questions with regards to your work on the electronic health records. If you could just talk and expand upon that, first by just talking a little bit more about how did you actually promote EHRs across the state? Did you promote a single vendor or promote a particular type of functionality? Then, did you require or encourage the use of certified EHR technology? So if you could just talk more about that.

ST: This is probably my weakest area, with the electronic health records, because this was taken on by our IT folks, who are a little bit more familiar. I know initially, when we did our behavioral health homes, they reached out to providers and they tied into hospital networks. They had agreements and they were doing individual. I know that the state is working on providing a central information center that would take charge, I guess, for this information. But as it stands right now, it's not limited to a single vendor. Like I said, we're working on pretty much filling that need. I don't know if it will go out and be bid on and they'll have a vendor that ends up doing it or not. Like I said, there's a whole separate team because it's pretty complex and there was a lot of need in that area. So they've pretty much been leading the way on that. I just know that it's a requirement for our behavioral health homes. When they come in, they've been given two years to integrate that healthcare information technology and start sharing the information with the providers that are offsite, or else they have to bring the providers onsite.

KVL: Great. Thanks so much, Steve. We have time, again, at the end of this webinar for further discussion and Q&A for both New Jersey and Washington. In the interest of time, I'm going to move on. We're going to ask participants to complete a polling question for us. It'll show up on this screen. The question is, and if you could just take a few minutes to complete it, what is your biggest challenge in planning an integrated care approach?

- Developing a vision for physical and mental health integration;
- Identifying a target population;
- Partnering across agencies;
- Engaging stakeholders;
- Resources priorities;
- Some other type of challenge.

We'll wait a few minutes and have you complete that, please. All right. We can see from these results that a majority, your biggest challenge are resources and priorities, followed by partnering across agencies, and then developing a vision for integration. So hopefully, we will be able to touch on some of this as part of our discussion at the end of this webinar. Thanks very much for filling out that poll.

Now, I'm going to turn it over to Colette Rush, who, again, is a behavioral health integration clinical consultant with the Washington State Health Care Authority. Again, Washington was one of the participating states. Colette?

Colette Rush (CR): Hi, there. Good morning, or afternoon, I guess, depending on where you are. I want to first thank the NASHP and CMS team and our coach Colette Croze for their support and assistance over the last year or so. It's been very helpful. Thank you. I'm one of the clinical staff on the team that is implementing integrated managed care across the state. I just want to say that an enormous number of individuals and agencies have been involved with many aspects of this work. This is starting from the early planning stages. So not any one of us, our department, are experts in everything, but we all have our particular focus areas. But if there are questions that I'm not able to answer, which is highly likely, we'll note those questions and I can get back to you on that.

The catalyst for us wanting to transform our system included some of these statistics on this slide and also, additionally, according to the most recent national survey on drug use and health, NSDUH, the 2010-11 data, 24% of Washingtonians met criteria for having a mental health disorder, such as depression or anxiety. These may not interfere with daily functioning, but they could have an influence over managing chronic medical conditions and may require treatment. And there were 7% with serious mental illness. At the time of the survey, Washington ranked among the top three states in terms of prevalence of adult with any mental health issues, illness, and this really concerned us.

So we had a siloed system of care and beneficiaries were navigating up to three different systems by different administrators. Mental health services for people with serious mental illness, those meeting access to care standards, were delivered through our regional service networks managed by DSHS. For clients with lower level mental health needs, Health Care Authority had mental health benefits through our Apple Health Managed Care programs or through fee-for-service program. DSHS contracted with the counties to manage outpatient services for substance use disorders and/or directly contract with residential treatment. Both of those sat outside our center, Apple Health Managed Care system.

For over 20 years, Health Care Authority and DSHS tried to make those two distinct managed care systems work together. We tried contracts, putting things in contract requirements, MOUs between MCOs and RSNs, education, training ventures, joint meetings, just to name a few of those. The fallows continued and there's been significant gaps in coordination.

There were also challenges as Steve also mentioned in his state. There were also challenges of multiple agencies managing our administrative financing and regulatory systems, things like licensing, credentialing, and regulatory oversight, to name a few. These agencies and their work developed over many years before the importance of integration had been recognized. And also, there's few incentives within our system or were to motivate entities to work together to meet complex needs.

So our question that we had to answer is how do we need to redesign or transform our Washington system of healthcare and what administrative structures do we need in place to support and derive integrated whole person care? Also included in this idea is what policy and regulatory levers could we use to accelerate transformation? One of my favorite quotes back from my transformation coaching years was from Donald Berwick, IHI's past president. He was also CMS' former administrator. I'm sure many of you have heard this quote, but it's perfect. "Every system is perfectly designed to get the results it gets." So Washington needed a new system.

We had an opportunity and we needed some help. We certainly could not have embarked on this scope without funding support. We received a multi-year testing grant in 2014 and after also receiving the SIMS Design and Pretesting Grant in 2013. These grants from CMMI enabled us to do early research data

analysis and engage in cross-community and cross-sector stakeholdering. We contracted with Manatt Health Solutions to jumpstart our efforts early on.

The next three slides come from a Manet presentation that included some of their research results at this early stage. Some early stakeholder interviews were performed with some of the findings listed here. The stakeholders are on the left. They discovered that although in some counties, there was better coordination of mental and SUD services, along with better connections with social services and the criminal justice system, there was still little coordination with physical health, and that was in our largest region, King County, that had that better coordination, but still not with physical health.

Care coordination requirements in contracts, like I said, did little to drive the coordination. Manatt also identified that the Medicaid expansion could strain provider capacity and there was wide disagreement on the solution to doing this. So this would be not the easiest and would require some extensive additional stakeholdering.

Manet also summarized integration experience we had in Washington that we might leverage. They listed examples of programs with behavioral health in primary care and primary care in behavioral health settings and community health centers that had all of those services at one site. I'm not going to go into the details, because of the time today, about each of those, but there's a little summary of each and you can certainly ask questions later if you would like about that, individual ones that I can answer probably after this webinar, more than likely.

Through this early research, we came up with three possible options or paths for Washington's future. The first option on the left column is just to resolve some of those key obstacles, but leaving the existing system largely intact. The middle column with integrate mental health and SUD services and we did select that as an interim model. We ultimately opted for the highest level of integration in the right column, although our design ended up even more integrated and centralized than what is reflected here, which I'll talk about later.

The middle option is in place now across the state until each region becomes fully integrated through managed care contracts, integrating physical health as well.

To design the system, we had to have major stakeholder involvement and input. We developed the public-private transformation to create action strategy, that's a mouthful, which was a consensus product built on a robust stakeholder process. We convened approximately 50 purchasers, health plan providers and thought leaders. They developed overarching goals and objectives for transforming the healthcare system. The emphasis was on aligning and implementing things that could be aligned and implemented across these groups and this particular group was primarily focused on hospital and ambulatory care settings, but we also in there decided that a sister document would be put together for the companies.

This transformation to create action strategy was an ambitious agenda for change and this required purchasers, health plans, state governments, providers, and other healthcare organizations to all agree with the objectives and strategies. So this was determined through a survey conducted with over 60 thought leaders. This represented a critical mass of these folks and it was done so we could confirm that there was an agreement and commitment to the transformation strategy across the state. I have to say, though, that there were hundreds and hundreds of people all across the state, all sectors, healthcare sectors, that weighed in our strategy over a year or so, or more, of work.

[next slide]

Future states.

[next slide]

There's a graph for future states. So a design of our new integrated systems started emerging for us. One of the first and most important priorities that I didn't state in this slide but I want to talk about is that we needed to regionalize the state and regionalize our transformation effort. At the time of this early research, the service areas were different for many state finance programs. For example, our Health Care Authority here, DSHS, Department of Health, Department of Labor, Industries, and Early Learning, and others, all used different service areas for their programs that affected health or healthcare delivery. We wanted to align these regions as much as possible. We decided to create up to nine regional service areas in the state. These RSAs would define regions for Medicaid procurement and allow for strategies for linking healthcare services systems to the community services and supports.

Recognizing that healthcare is local and communities understand the needs of their populations, they need to be empowered to develop their own strategies. To do that, we have to align the service sectors to the same regions.

Also, the stakeholder interviews strongly agree that health systems need to be able to address prevention and social determinants of health and part of a broader community of health and that we needed to move away from fee-for-service reimbursement system. They also said that there should be support for practices integrating care at the clinical level and that we should definitely integrate the purchasing of care for the full continuum of services, physical and behavioral health services.

Washington decided as the largest healthcare purchaser in the state between its Medicaid procurement and its public employees it would take a lead role as first mover. So the state would lead by example by changing how it purchased care and services in our state purchased instruments program.

[next slide]

Accountable communities of health were developed to support those regional efforts and AC just reformed one in each of the nine regions. They embody a paradigm shift. They emphasize the role and influence of regional partners and these regional partners shape the system to be responsive to their local population. They could address health, healthcare delivery, and the critical social determinants of health. Accountable communities of health would have multiple roles in driving our transformation, which is how it's turned out since our design. They could be a partner in Medicaid procurement because the procurement regions and ACH regions are aligned along the same geographic borders. Also, the Washington legislature required that the counties give approval for the term of implementation in their region. So the ACH would help us forge those new relationships.

This requirement for the counties was leveraged into a new relationship between counties and states, and I have to say as a side, this has been really critical to our success and before that, maybe it was a little bit of a barrier. The counties are actually involved in setting Medicare contract standards, reviewing health plan bids, and have a role in readiness and monitoring of health plans' performance. ACHs will be expected to complete a region-wide health assessment and planning to identify strengths and gaps in assets. Still

active before and for aligning payment models and performance measures and getting HIE out there into the community and working on workforce development.

[next slide]

This was what was designed, and much of that was implemented, the nine RSAs and the ACHs were created. There were other key elements that helped us get where we are.

[next slide]

Legislative support was key and in 2014, there was a governor request legislation to support healthcare transformation. The state of Washington was given an unprecedented opportunity to implement a five-year state healthcare innovation plan. This was developed through CMMI to transfer from healthcare delivery systems. Additionally, in 2013, the legislature adopted two bills. This required the state to establish outcomes, expectations, and performance measures in its purchasing of medical behavioral long-term care and social support services, thereby aligning outcomes across sectors.

[next slide]

Because of the state innovation model grant from CMMI and the 2014 legislation, HCA formed Healthier Washington to lead these implementation efforts here. Healthier Washington has three primary strategies, including whole person care, building healthier communities, and paying for value. Then, the nine goals, you can see on these two slides, this slide and the next slide. I'm not going to read through those, but those are the nine goals that they are focusing on.

[next slide]

Leveraging data analytics. We are using and developing important data analytics. Washington is one of the few states in the nation with an integrated social service client database. So we receive claims and encounter data from individuals receiving services across state-funded social and health programs. The database is also linked to other sources, such as crime, incarceration, school, and employment data.

We were also awarded a federal grant to build an all-payer claims database. This database reports on measures from the statewide common measures, which is a set of measures generated from another large stakeholdering process. These are high value performance measures selected to be used across stakeholder groups to evaluate performance and progress.

We are also developing a clinical data repository, which will allow authorized individuals access to real time integrated medical, dental, behavioral health, and social services data for Apple Health enrollees. This is clinical data that you can't really get through claims data and is really a final necessary data tool for us to understand if outcomes are improving.

Finally, Washington's health mapping partnership that's been around since 2006, we use GIS mapping, which provides new ways of seeing and improving health outcomes in targeted areas.

[next slide]

Washington has systems and entities that have provided some great leadership in moving toward quality improvement. I'm only going to highlight one of these because of the time, but you can look these up online if you end up being interested in them. But Dr. Robert Bree Collaborative is a statewide public-private consortium established in 2011 by the Washington State legislature. Bree members are approved by the governor and include representatives from public and private healthcare purchasers, employers, health plans, providers, and quality improvement organizations. The Bree identifies up to three areas annually where there is substantial variation in practice patterns and/or high utilization trends. The group gets together and makes recommendations for improving outcomes. Recommendations from the Bree are sent to the Health Care Authority to guide state purchasing for programs such as the Public Employees Benefit Board and Medicaid.

To date, Bree has completed reports and provided quality improvement and payment reform recommendations for obstetrics, cardiac care, appropriate use of PCIs, spine and low back pain, end of life, and addiction to opioid use. They also provided recommendations for integration of behavioral health into primary care and they're going to this year, in the next year or two, do primary care into behavioral health centers. The state has endorsed those recommendations and they are referenced in contracts and demonstration waiver toolkits.

[next slide]

The practice transformation support is an investment area of Healthier Washington and is managed by the Washington State Department of Health. The hub delivers tools, technical assistance, training, and on-site coaching and support to providers in small to medium physical and behavioral health practices. This coaching is really critical to transforming at the clinical level. Their goals are to achieve bidirectional integration, move from volume to value-based care, and improve population health to the community linkages.

[next slide]

We've developed integrated managed contracts for Medicaid beneficiaries. We have done that and those are chosen after a competitive procurement process and they provide a full continuum of physical, mental health, and substance use services within their scope. Medicaid benefits continue to be defined by the state plans. Each region will have a minimum of two managed care plans and a maximum of five to provide consumer choice.

In April, we launched integrated managed care in the Southwest Washington region, our first region, and in January of 2018, we launch our second region in fully integrated managed care. MCOs are subcontracted to what we call as behavioral health administrative services organizations, which manage initial crisis response services and court functions. And also, the managed care agencies manage the behavioral health services for individuals with primary care under some other mechanisms, such as Medicare, and those are called the behavioral health services only benefits in those regions.

Finally, no matter when a region goes forward, the implementation process requires a high degree of collaboration between providers, MCOs, county, BHO staff, and the state. That brings me to the end of my talk. Thank you.

KVL: Great. Thank you so much, Colette. We now have time for some questions and answers for Colette. Again, if you have a question, please type your question into the chat box. While you are doing that, I just

want to — we've gotten a couple questions about the slides and I just want to announce that the slides will be available later this week. So please look for the slides and, yes, they will be available.

For our first question, Colette, I'm wondering if you could just expand upon how the statewide common measures set was developed. I know many states are interested in doing that or are doing that and it can be quite challenging. Can you just expand a little bit more about that particular piece?

CR: Right. Health Care Authority led that effort. It was a large stakeholdering group, providers, purchasers, employers, consumers were all representing on these groups. It's an ongoing group to continue to define what measures we want to select in the state to make certain that all sectors are kind of using the same performance measures.

Those are mostly things that are already well vetted. Those measures are already well vetted nationally and right now, it's mostly through claims data, where we can get it administratively or through claims data in our state, through some of the mechanisms I mentioned on the slide set. As we get clinical depository or more clinical information pulled into databases, we could expand on that. And so, the stakeholder group continues to select measures.

We also had some legislation I had mentioned, in 2013, which mandated that we had cross-agency work on selecting measures for certain outcomes. Outcomes were all across the health sector, wellness, quality of life, criminal justice, housing, and select those measures. There was two years of work done there and that kind of also informed some of this common measures set of measures.

KVL: Thank you. Our next question is with regard to the role of consumers. Can you talk a little bit about the role of the consumers in the redesign, especially at the local service delivery level?

CR: Yes. This was done pretty early in the planning stage and continues to go on. So I mentioned the stakeholders that got together and were interviewed by Manet in the early years. But we've had many consumer public forums to have folks weigh in on what — to present the design that we're thinking of and have folks weigh in on that, also voice their concerns about healthcare in the individual regions. So that was early on.

Again, when we developed the design, we had hundreds and hundreds of people weigh in, and that included consumers that were in our e-mail stream and a lot of the professional stakeholders we had in our group would tie into their individual consumers that they worked with to get input. As we integrate into the specific regions, we have consumer forums. We just had a consumer forum in our second region that we're launching in January. We just had one about three weeks ago, again to review the input for the design and get their input.

There's also a lot of consumer involvement through the ACHs. There's consumer advisory boards, lots of different elements that are probably missing and probably missing quite a few avenues in which we engage the consumer.

KVL: Thanks. There is another question about the ACHs. Do the ACHs in Washington have a role in deciding how payment is made for integrated care?

CR: So value-based payments arrangements, I'm assuming? They have — yeah. I didn't mention this, but there can be an inter-local arrangement, inter-local group, that could be established in the regions

separate than the ACH, but working closely with ACH. They can drive kind of the design in the regions. I wouldn't say that is changing how the care will be paid for, but they do have great input into the design within the region. I don't know if that answers the question. I probably have to do a little bit more exploration on that question.

KVL: Thanks, Colette. That's really helpful. I think now, in the interest of time, we're going to move to our next and final polling question. This is a question that's asking participants to weigh in about your own internal challenges that your state is encountering. What are some of the internal challenges your state encounters in planning an integrated care approach?

- Services administered separately;
- Carved out behavioral healthcare;
- Licensing and regulatory barriers;
- Or other changes that you can type into the chat box.

We'll take a few minutes to let folks respond. Quite significant response is just the fact that services are administered separately, nearly 67%, followed by carved out behavioral healthcare. So again, very helpful for us and hopefully, we can kind of come back to this as part of our facilitated discussion.

So with that, I just want to thank Steve and Colette for your very thorough and helpful presentations. Now, I'm going to turn this over to my co-facilitator Colette Croze, who, again, was one of the coaches and was the coach working with New Jersey and Washington state. She's going to just have facilitated discussion and, again, continue to answer some of your questions. Again, if you have questions, please type those into the chat box. Colette?

Colette Croze (CC): Thanks, Karen. I'm going to build on the results from the polls and structure some questions for Colette and Steve. In the first poll, we heard about challenges being resources and priorities and then working across silos. I want to ask this question of Colette. I'm always impressed when you describe the various moving parts in Washington. I mean, the practice transformation support hubs, the Healthier Washington, the accountable communities of health. How are you guys able, first, to garner the resources to have such a multifaceted transformation effort? Then, how do you keep them all moving in the same direction?

CR: That's a hard question. Well, I mean, first of all, the CMI funding was critical, those designs, a design grant and then the implementation grant. Then, we also just recently, at the end of last year, received a demonstration waiver grant that was significant dollars for our state. We couldn't have done this without some significant funding. We couldn't have done this without the top leadership, which is the legislature and the governor, saying this will be done. That kind of directs Health Care Authority and Medicaid to get it done. I mean, that's huge, actually. Then, sometimes it's hard to keep everybody on the same — I think that's probably the biggest barrier or challenge, is keeping everybody — not barrier, challenge, keeping everybody on the same track. The ACH is the practice information of all the things you listed. But the Healthier Washington group takes kind of a lead on this and all of us are very committed to the work. I think we all are sensitive. We remind each other to be sensitive, that, wait a minute, doesn't sound like this is aligning with our sister group over here. So we meet. It is a work in progress, I have to say, and I think we all see every month that it gets tighter and tighter as we pin down our design. I'm not sure if that answers your question. It is the largest challenge we face, I think, right now.

CR: It's quite a large transformation. Thank you, Colette. Steve, I want to go back to working across the state silos because you had talked about that a lot in your presentation. If you had to pick one issue, one occurrence, one activity that really got folks across those state agencies together and led them to create the kind of interagency process you described, what would that be?

ST: I think for New Jersey, it was probably the expansion of the SUD services. That forged a very good working relationship with the Division of Mental Health and Substance Abuse and Medicaid. Then, there was also that natural where our integration started with mental health and then mental health became behavioral health. We just kept that close working relationship and started moving where we had basically behavioral health homes that were focused primarily on mental health. We started talking about bringing in substance abuse. That was probably the biggest thing that helped us to get a lot of our work done. It was almost like we were a single agency by the end. We're still working, but —

CC: Thank you. I want to pick up one of the questions that we had in the chat box. I think maybe Colette, you could give us some thoughts on this. The person asked are there particular changes in service delivery that are either needed or seen when behavioral health and physical healthcare is integrated? Either changes in delivery or changes in the way of thinking about delivering care. What have you observed?

CR: Yeah. I think so. One of the most recent actually discussions I've had is around SUD services and that is considering — I don't think SUD has been considered a chronic condition, like mental health conditions or some of the medical conditions. To change how we deliver services and how we integrate SUD into the rest of the care, we have to consider it in that same way. Then, it would lend itself to the integration event-based models, integrated models, that are out there more aptly. I would say that was one area right there.

Then, looking at evidence-based integration models, like collaborative care, the collaborative model, and to use the multidisciplinary team approach to looking at those conditions together. So really, whole person care. There's many other things I could probably say about that.

CC: Let me go to some of the responses to the second polling question about internal challenges, and the biggest one being separately administered systems. Washington, since you're moving through the separate to the integrated, what was it that either the governor's office, legislature, stakeholders, whomever, that really gave people what I'd call the courage to say the system should be together, not separate?

CR: I think the data that were polling around the percentage of folks with medical conditions, with mental health conditions, and also those with behavioral health conditions with chronic disease. We see that people — we need to look at the person holistically and treat all things when somebody is seen and setting is an opportunity to look at all needs of the patient. So until we have integrated those aspects of the continuum of healthcare, we can't really address them well. I forgot the rest of your question. Sorry.

CC: What was it that sort of was a tipping point for folks within Washington state to say we are not going to leave those three systems separate, we're going to bring them together?

CR: I don't know what the tipping point was. It was early on in our work and — yeah. I mean, this was several years ago, prior to me. I mean, I think that we had the data and then we had the funding in order to evaluate our system and we realized it wasn't working. The coordination was just not occurring between the different entities and it needed to improve. The only way we could improve it is by

integrating and the stakeholders really felt that the financing and management of these three areas had to come together. Until we did that multidisciplinary team care, true integration couldn't occur, coordination couldn't really occur, no matter what we did incrementally to the system. We just couldn't do it unless that financing was aligned. I guess that was things that happened to make it tip over and the legislative mandate. The governor in his first year, he had a very ambitious goal to change our healthcare delivery system in his first few months of office.

CC: Thanks. Steve, I'm going to go back to you on the topic of separate administration. It's clear that the state agencies are working together very closely. You still do have some silos, right, in that you've got mental health and SUD services basically managed through the behavioral health group? Then, you've got the managed care contracts definitely through Medicaid. If you had to look into a crystal ball, what do you see as the next steps in bringing those closer together?

ST: I honestly think that when we do our rules and regulation revamping as part of the work that the governor's office is promoting that that is going to play a large part in eliminating some of the turf wars that we have. We've already started now, like with our Medicaid regulations, where we just refer to the Division of Mental Health and Substance Abuse for any of the policy-type information. We cope with a lot of misinformation and confusion when our regs would say 90 days and theirs would say three months, and things like that. Just little things that made a big difference and then we would get into a turf war over which ones should be enforced.

So I think that when we get the regulations all kind of cleaned up and where we're not worried about the little things and we can focus more on the outcomes, that seems to be the direction that we're moving now. Again, most of our work was primarily with the Division of Medical Assistance, but when they converted all the state contract dollars over to Medicaid, that was a huge loss of authority, I guess you would call it. There's now another player that's involved, but, like I said, it's going really smoothly. I think they appreciated the fact that by doing that, they were able to maximize their dollars and provide services to a lot more people. We're just beginning the work with the Department of Corrections, like I said, on the prison reintegration project. Again, we share a common goal. They identified a couple barriers that we at Medicaid just aren't able to address at this time, but things like their prisoners, their biggest issue was finding them housing when they come out. So they wanted to refer them to a program where they could get adequate housing. They felt that was more of a priority than getting them into a behavioral health home.

So little things of that nature, but as we expanded, we can get more into the social issues, like that were identified in the Rutgers report. Then, I think that we'll be in much better shape, as long as we keep the clients in the forefront, and that's the thing we're trying to serve. I think we'll all be okay.

CC: Great. We had a question in the chat box that we didn't get to. It had to do with pay for success, which I'm going to translate to value-based purchasing. And so, I wanted to ask Colette if you give us some background on what Health Care Authority has set as their plan for using alternative payment models and how you're working with the full integrated management plans around that.

CR: Okay. Yeah. We have kind of a roadmap for getting there over the next four years and in our Apple Health Contracts, our integrated contracts that are Apple Health, regular physical health contracts, we did put contract language in for 20% of the practices they contract with to have value-based payment arrangements. In 2018, we're going to expand that to those integrated managed care plans so that it

impacts two of the regions where we've expanded to and we'll be successfully progressing across the state.

In 2019, we want 90% of those arrangements that managed care has with practices to be value-based payment arrangements and then 90% in 2021. What we do is that there's a 1% withhold of their total monthly premium payment and up to 12.5% of 1% may be earned back by making qualifying provider incentive payments that they do in these value-based payment arrangements. Up to 12.5% of 1% percent may also be earned by having the value-based purchasing arrangements and then 75% of 1% may be earned if quality improvement targets are reached.

So that's basically what we're doing. There is a set of nine quality measures for the Apple Health Contracts and next year, when we extend into these integrated regions, we'll be adding behavioral health and integration type measures for those, I think, as we haven't made any final decisions, but I think that's four of them that will be used in the BDP arrangement.

We are following the HCA's LAN national guidelines and I should have put that out. You probably know that and we're following that model and using some of those categories and LAN is our guiding incentive models.

CC: Great. Thank you. Thanks, Steve and Colette, for answering these additional questions. I'm now going to turn it over to David for wrap-up and what's going to happen going forward.

DS: Thanks, Colette. Appreciate everybody's attention today. Really appreciate all our presenters as well. I think this has been a really helpful discussion, very interesting, and I know that it has a lot of relevance for efforts in other states. So I hope that has been helpful to all of you.

We have three further webinars. Specific dates have not yet been scheduled, but here, you can see the rough timeline for the upcoming segments of our national dissemination strategy. The next session will focus on building a measurement strategy that drives PHM integration. So looking at quality measures and how those fit into your integration strategy, including both process measures to think about how to determine whether integration is working as well as outcome measures in terms of looking at the impact on the population.

Next, we'll be looking at administrative and reimbursement strategies and then, finally, supporting practice transformation for physical and mental health integration. What are the leverage points that states can use to support the providers in participating in these efforts? So hope you will join us for those. Please stay tuned. They'll be announced through our SODA listserv as well as through the NASHP newsletter and potentially other outlets that you get news from. Hope you will join us for those in the future.

Thanks, everyone, for joining us today. Please don't forget to fill out the evaluation that will pop up when you close out. We really do look at those carefully and they help us to figure out how we can tailor the content and the delivery of these types of webinars to be useful to you. So when you take the time to think through the answers, we really do think about that and it does have impact on the way that we will be designing future efforts.

Thanks again, everyone, and with that, I think we will close the call.

[end of tape]