

Medicaid Innovation Accelerator Program

Physical and Mental Health Integration

**Planning a State Approach for
Physical and Mental Health
Integration: Key Steps and
Considerations**

**National Dissemination Webinar
July 24, 2017, 2:00pm-3:30pm ET**



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Agenda

- Welcome and introductions
- Overview of the Medicaid Innovation Accelerator Program (IAP) Physical and Mental Health Integration (PMH) initiative
- Overview of planning and developing a PMH integration initiative
- Insights from two participating states
 - Washington
 - New Jersey

Facilitators

- **Karen VanLandeghem**, Senior Program Director, National Academy for State Health Policy (NASHP)
- **Colette Croze**, Principal, Croze Consulting

Presenters

- **David Shillcutt**, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services
- **Kitty Purington**, Senior Program Director, NASHP
- **Steve Tunney**, Chief, Behavioral Health, New Jersey Department of Human Services, Division of Medical Assistance and Health Services
- **Colette Rush**, Behavioral Health/Integration Clinical Consultant, New Grants and Programs, Washington State Health Care Authority

Overview of Medicaid Innovation Accelerator Program (IAP) Physical and Mental Health Integration (PMH) Initiative

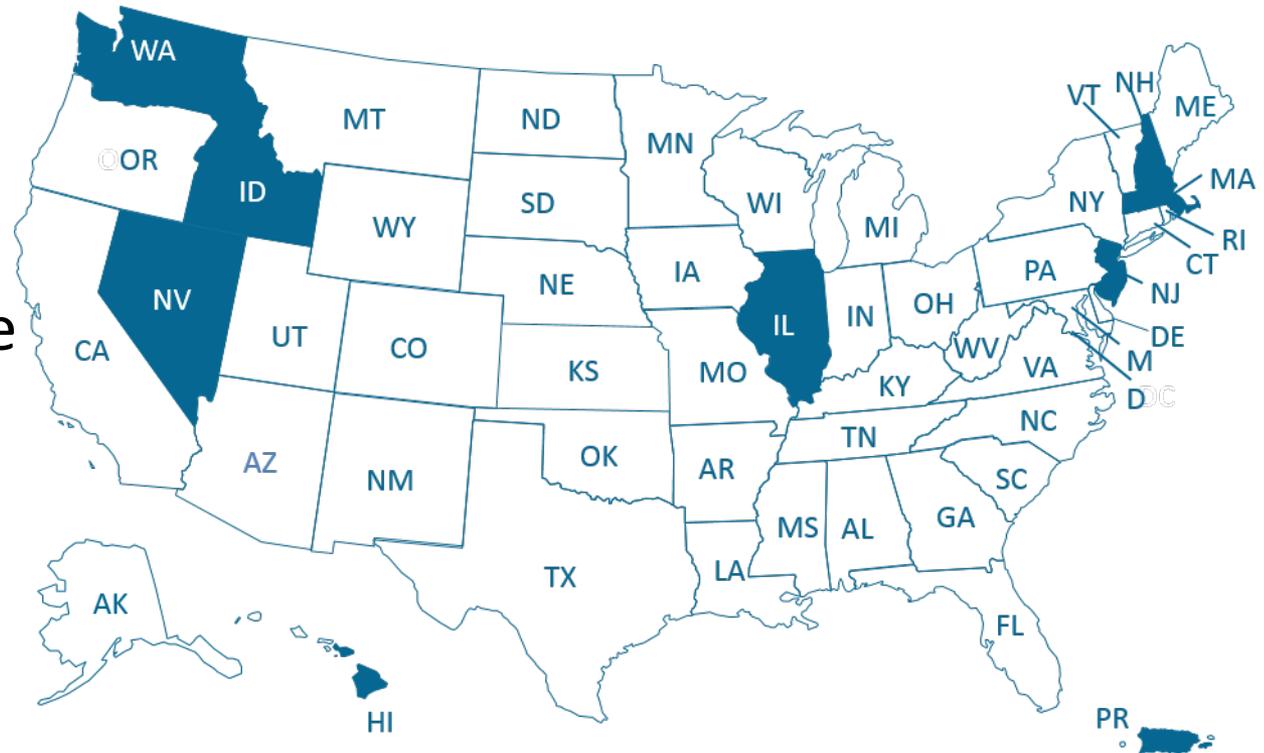
David Shillcutt

Background

- IAP worked with nine states over twelve months to enhance or expand diverse integration approaches by providing technical support on issues such as:
 - Administrative alignment
 - Payment and delivery system reform
 - Quality measurement
- This webinar is the first in a series of four national dissemination webinars for the IAP Physical and Mental Health Integration program area
- Today's focus: state considerations when planning and developing a PMH integration initiative

Participating Teams

- Idaho
- Illinois
- Hawaii
- Massachusetts
- New Hampshire
- New Jersey
- Nevada
- Puerto Rico
- Washington



Planning a PMH Initiative: What we can learn from current state efforts

Kitty Purington

Key Considerations

- Develop a working definition or model of integrated care
- Use data and other information to identify integrated care needs and opportunities
- Work across state siloes through cross-agency partnerships
- Engage stakeholders

Planning a PMH Integration Approach: New Jersey

Steve Tunney, RN MSN

Chief, Behavioral Health

NJ Department of Human Services

Division of Medical Assistance and Health Services

New Jersey's Vision for Physical and Mental Health Integration

- Expand network of integrated providers across the care continuum
- Target Serious Mental Illness (SMI) and Substance Use Disorder (SUD) populations
- Fully integrate managed care coverage
- Expand managed care's role in managing non-traditional services

New Jersey Drivers for Change

- Study by Rutgers University Biomedical and Health Sciences. Findings include the need to:
 - Improve overall care provided by NJ FamilyCare
 - Specifically address high-cost “super utilizers”
- Stakeholder input
- Poor health outcomes for behavioral health clients
 - Decreased life expectancy-25 years
 - Modifiable Health Factors-Metabolic Syndrome

Data Used to Drive Change (1 of 2)

- Analysis and Recommendations for Medicaid High Utilizers in New Jersey
- Five recommended areas to advance:
 1. Integration of behavioral and physical health
 2. Populations with persistently high costs
 3. Coordinate social service and public health initiatives with Medicaid
 4. Adopt best clinical practices
 5. Strengthen infrastructure and accountability

Data Used to Drive Change (2 of 2)

- Data-supported efforts to pursue integrated care:
 - High re-hospitalization rates/over utilization of emergency room
 - Department of Correction (DOC) data showed 80% noncompliance with scheduled appointments after release
 - DOC data showed increased mortality within 30 days of release
 - New Jersey Substance Abuse Monitoring System (NJSAMS)- statewide utilization of state and Medicaid dollars
- Rutgers Biomedical and Health Sciences
 - High-level interstate research
 - Valued Base Payment/PMH Integration background resources

Initial Planning: Internal Team

- Core team: Bi-weekly meetings
 - Department of Human Services (DHS):
 - Division of Mental Health and Addiction Services
 - Division of Medical Assistance and Health Services
 - Office of Business Intelligence
 - Director of Behavioral Health DHS
 - Leadership
 - Commissioner of Human Services
 - Deputy Commissioner Human Services
 - Director Behavioral Health
 - Monthly updates to the Director
 - Director of Policy Development

Key Stakeholders (1 of 3)

- Independent clinics
 - Primary mental health providers
 - Earliest providers seeking integration of care
 - Explored early partnerships with Federally Qualified Health centers (FQHCs)
 - Shared space

Key Stakeholders (2 of 3)

- FQHCs
 - Physical health providers with desire to provide behavioral health
 - Licensing issues
 - Scope of work
 - Prime locations
 - Prospective Payment System (PPS) encounter reimbursement

Key Stakeholders (3 of 3)

- Hospital Networks
 - Movement into community
 - Resources
 - Statewide, urban presence
 - Licensing issues
 - Billing issues
 - Medicaid Management Information System (MMIS)
- Managed Care Plans
 - Network of providers
 - Coordination of care

Lessons Learned (1 of 2)

- Challenges
 - Scheduling meetings: requires commitment
 - Anticipate needs early: gather necessary data
 - Maintain momentum
 - Electronic Health Records
- Planning/development of a PMH integration approach
 - Anticipate needs and have the right people in the room
 - Maintain stakeholder support/assistance
 - Consider a dedicated position to coordinate and direct

Lessons Learned (2 of 2)

- Engaging stakeholders
 - Maintain regular contact with those affected by potential change
 - Recognize that not all stakeholders share common goals
 - Listen as well as propose
 - Formal and informal meetings
 - Engage stakeholders
- Unanticipated issues/barriers
 - Competing priorities: expansion of SUD services
 - Licensing by multiple departments
 - Budgetary concerns

What was Helpful? (1 of 2)

- Reviewing activity of other states
 - Benefit of FQHCs in integration- Indiana
 - Covering group therapy in FQHCs
 - Washington DC: 1/5 of total encounter
 - California: group therapy built into PPS encounter rate
 - New York: uniform reimbursement rate for mental health
 - Hub and Spoke health home model for SUD homes
 - Vermont: Medication assisted treatment providers are Hub and FQHCs are spokes ([Vermont Hub and Spokes Health Homes](#))

What was Helpful? (2 of 2)

- Resources- Value-based payment/PMH Integration
 - [Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches](#) (Center for Health Care Strategies Brief)
 - [Behavioral Health Integration in Primary Care: A Review and Implications for Payment Reform](#) (Mathematica Policy Research Brief)

Current/Next Steps

- Planning and implementation is ongoing
 - Reorganization of licensing to a single licensing authority
 - Re-alignment and focusing of statutes and regulations
 - FQHCs provision of limited BH services/integration of care
 - Reviewing managed care organization contract language
 - Expansion of telemedicine services
 - Hub and Spoke model for SUD
 - DOC prisoner referrals to behavioral health homes
 - Comprehensive Waiver 1115 changes
 - Expansion of Electronic Medical Record usage

Q&A

Poll Question #1

- 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
 - Other (type in chat box)

Planning a PMH Integration Approach: Washington

Colette Rush, RN, BSN, CCM

Behavioral Health/Integration Clinical Consultant

New Grants and Programs

WA State Health Care Authority

Where We Were

- 75% of Medicaid enrollees with significant mental health and substance use disorders had at least one chronic health condition
- 29% of adults with medical conditions have mental health disorders
- Three systems of care with different administrators:
 - Mental health for population with serious mental illness
 - Physical and mental health care for general population
 - Chemical dependency services

The Question

- People
 - Physical Health, Mental Health, and Chemical Dependency Needs
- Providers
 - Physical Health Providers
 - Mental Health Providers
 - Chemical Dependency Providers
- Systems of Care
 - Physical Health System
 - Mental Health System
 - Chemical Dependency System
- Administration
 - Physical Health Administration
 - Mental Health Administration
 - Chemical Dependency Administration

What system & administrative structures will support integrated care delivered by providers to patients?

Opportunity

CMMI State Innovation Model Grant

- Multi-year State Innovation Models Testing Grant awarded for application submitted in December, 2014 (joint effort for Health Care Authority and Department of Social and Health Services)
- Contractor hired to:
 - Analyze the degree to which Washington’s current physical and behavioral health services were fragmented or integrated;
 - Identify models and opportunities to integrate service delivery;
 - Improve the use of team-based care;
 - Analyze payment policies.

Research and Stakeholder Process

Early Research Findings

Stakeholders Interviewed:

- Regional Support Networks
 - Single-County
 - Multi-County
 - Private
- County Chemical Dependency and Social Services Departments
- Healthy Options Plans
- Community Mental Health Agencies
- HCA and DSHS Representatives
- Legislative Staff
- Researchers

Findings:

1. Physical health, mental health and chemical dependency systems operate in separate silos, with limited coordination and integration
2. In some counties, there is considerable coordination of mental health and chemical dependency services, social services, and the criminal justice system; coordination with physical health occurs less frequently
3. Care coordination requirements in contracts have not resulted in widespread care coordination on the ground
4. Separate legal, regulatory and reporting requirements impede coordination and integration
5. Medicaid expansion will strain provider capacity and exacerbate lack of coordination and integration across systems and provider types
6. Interviewees generally agree that current system structures impede coordination and integration; however, there is wide disagreement on the solution

Scan of Washington's Experience with Integrated & Coordinated Care (1 of 2)

Behavioral Health in Primary Care Settings:

- Mental Health Integration Program (MHIP)
 - Integrates mental health screening and treatment into community health centers statewide through a collaborative approach including a PCP, a care coordinator, and a consulting psychiatrist
- COMPASS
 - Leverages collaborative care management models to treat adults who have depression and diabetes and/or cardiovascular disease, in primary care settings
- Community Health Centers
 - Many provide colocated and coordinated physical health, mental health, and chemical dependency services
- Kitsap Mental Health Services
 - Provides psychiatric consultant services for Kitsap-area PCPs
 - Provides brief behavioral health intervention services at four primary care sites

Scan of Washington's Experience with Integrated & Coordinated Care (2 of 2)

Primary Care in Behavioral Health Settings:

- SAMHSA Primary and Behavioral Health Care Integration (PBHCI) project sites
- Kitsap Mental Health Services
 - Collocates a primary care provider on-campus to provide services to individuals with significant physical and behavioral health needs
 - Using federal grant funds to train and employ multi-disciplinary Adult Outpatient Care Teams (including medical assistants linked to primary care) and expand HIT and data-sharing capabilities
- MultiCare Good Samaritan Behavioral Health
 - Provides primary care at Pierce County community mental health agencies through a mobile van staffed by a primary care team
- Other Community Mental Health Agencies
 - Several agencies partner with PCPs to offer services on-site, some through relationships with FQHCs and hospitals

Presented New Options for Washington

Resolve Major Obstacles, Leave Existing Systems Largely Intact

- Retain current division of responsibility between HCA, Healthy Options, RSNs/BHOs, and counties
- Competitively procure BHO contracts; RSNs compete
- Resolve impediments to better coordination and integration including:
 - Data sharing
 - State reporting infrastructure
 - Streamlined & coordinated assessment tools
 - Aligned and simplified regulatory requirements
 - Strengthen requirements and accountability (including incentives and penalties) in state contracts

Integrate Mental Health and Chemical Dependency Systems

- Establish behavioral health organizations (BHOs) with responsibility for MH *and* CD
- Expand role and accountability of RSNs to include chemical dependency and mental health so that they may qualify as BHO
- Carve out all CD and BH benefits to BHO
 - Provide counties with first right to contract for BH/CD services
 - Require BHOs (and HOs) to coordinate with county services (jails, courts, EMS)
- Develop stringent coordination and data sharing requirements subject to incentives and penalties between BHOs and physical health systems
- **Example:** Pennsylvania HealthChoices

Centralize Responsibility for all MH, CD & Physical Health

- Accountability for full spectrum of physical health, MH, and CD services in managed care arrangements
- Competitively procure MCO contract; HOs and RSNs could bid
 - Global capitation, shared savings or other risk bearing arrangements supported by subcontracts as warranted
 - Define role for counties in the delivery of CD and MH services through service level agreements
 - Certain plans could be designated for SMI population
 - Defined requirements, incentives and enforceable penalties
- **Example:** New York Medicaid Managed Care, Oregon CCOs, WMIP, HealthPath



Stakeholder Engagement

- Implemented the “Public/Private Transformation To Create Action Strategy”
 - Convened approximately 50 purchasers, health plans, providers, thought leaders from across the state;
 - Developed overarching goals and objectives for transforming health care delivery system;
 - Emphasis on strategies that can be aligned and implemented across multiple payers, providers, and purchasers to accelerate health care transformation;
 - Primary focus on hospital and ambulatory care settings.

Future State

Future State

Current System:

Inconsistent/weak linkages between clinical and community interventions.

Lack of incentives/supports to coordinate multiple aspects of an individual's health and health care.

Financing and administrative barriers to integrated, whole-person care.

Disjointed diversity of payment methods, priorities, and performance measures.

Slow adoption of alternative, value-based payment.

Relevant clinical/financial information often unavailable for provision of care and purchasing decisions.

Transformed System:

Health systems positioned to address prevention and social determinants of health as part of broader community of health.

Support at state and local levels for practice transformation that emphasizes team-based care.

Emphasis on regionally responsive payment and delivery systems, driven by integrated purchasing of physical and behavioral health care.

State leadership in deploying innovative purchasing models and requirements that drive value over volume.

Alignment between public and private purchasers around common measures of performance with value-based payment as the norm.

A transparent system of accountability, allowing purchasers, consumers, providers, and plans to make informed choices.



Better Health
Better Care
Lower Cost

Development of Accountable Communities of Health

- Accountable Communities of Health (ACHs) embody a paradigm shift that emphasizes the role and influence of regional partners.
- Shaping a health system responsive to local population health and health care delivery needs while addressing critical social determinants of health.
- Washington is seeking to transform more than clinical care, because much of health is determined by the physical and social environments in which individuals and families live.

How to Get There

Legislative Support

- 2014 Governor Request Legislation to support healthcare transformation
 - Subsequent legislation:
 - Directs state to fully integrate the financing and delivery of physical health, mental health and substance use disorder services in the Medicaid program via managed care by 2020.
 - Requires the HCA and the Department of Social and Health Services to restructure Medicaid procurement to support integration of services for physical health, mental health, and substance abuse.
 - Directed the DSHS and HCA to base contract performance assessment for Medicaid funded, mental health, chemical dependency, physical health and long term care services on common outcomes.

Common Vision: 'Healthier Washington'

(1 of 2)

- Goal 1: Supporting Communities
 - Accountable Communities of Health have the capacity and mechanisms to be responsive to partnership opportunities & community priorities.
- Goal 2: Spreading Value
 - Increase the number of providers and payers engaged in Healthier Washington payment models.
- Goal 3: Empowering People
 - People & their families are engaged as active participants in their health and in health systems transformation efforts.
- Goal 4: Supporting Providers
 - Providers are supported in moving to team-based, integrated care.

Common Vision: 'Healthier Washington'

(2 of 2)

- Goal 5: Rewarding High-Quality Care
 - Providers are supported in moving to value-based arrangements.
- Goal 6: Ensuring Whole-Person Care
 - State financing and administrative approaches promote integrated and coordinated service delivery in physical & behavioral health settings.
- Goal 7: Sharing Data
 - State, community, & provider information systems support integrated, team-based care.
- Goal 8: Using Data
 - Washington State has the data and analytic infrastructure in place to support and sustain health systems transformation.
- Goal 9: Sustaining Success
 - Washington State is leveraging partnerships, financing, & policy to ensure health systems transformation endures.

Leverage and Expand Existing Data Analytics

- Washington State's Integrated Client Database
- Expand Multi-payer claims database to All-Payer Claims Database (Medicaid, Medicare, Private)
- State-Wide Common Measure Set
- Clinical Data Repository
- Washington's Health Mapping Partnership

Leverage Health, Clinical, and Quality Improvement Activities and Measures

- Dr. Robert Bree Collaborative
- Washington Health Alliance
- Foundation for Health Care Quality
- Qualis Health
- University of Washington AIMS Center
- The Health Technology Assessment Program
- Community collaboratives and WA's hospital, medical and other professional associations
- Community/regionally –based health improvement organizations

The Practice Transformation Support Hub

Through the Healthier Washington Practice Transformation Hub, providers, practices, and behavioral health agencies across the state have access to free services to support practice transformation.



Where We Are Now, Next Steps

- Integrated MCO contracts for Medicaid beneficiaries
- April 2016: Southwest Washington became the first region to launch a fully integrated managed care model
- January 2018: North Central (Grant, Chelan and Douglas Counties) will launch fully integrated program
- All 9 ACH regions have received first level certification for regional assessments and projected plans
- 2020: All nine regions required to be fully integrated

Q&A

Poll Question #2

- What are some of the internal challenges your state has encountered in planning an integrated care approach?
 - Behavioral health and physical health services are administered by separate agencies.
 - Some or all behavioral health services are carved out of managed care contracts.
 - Licensing and other state regulations do not support integrated care.
 - Other (type in chat box)

Discussion

Colette Croze

Principal, Croze Consulting

State Speaker Contact Information

- Steve Tunney, RN MSN
 - New Jersey Department of Human Services, Division of Medical Assistance and Health Services
 - Steven.Tunney@dhs.state.nj.us
- Colette Rush, RN, BSN, CCM
 - New Grants and Programs, Washington State Health Care Authority
 - colette.rush@hca.wa.gov

Upcoming IAP PMH Activities

National Dissemination Webinar	Date
Building a Measurement Strategy that Drives PMH Integration	September 2017
Administrative and Reimbursement Strategies	November 2017
Supporting PMH Practice Transformation: State Leverage Points	January 2018

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