

Medicaid Innovation Accelerator Program Physical and Mental Health Integration

**Medicaid Strategies for Promoting
Provider Capacity for Physical and
Mental Health Integration**

**National Dissemination Webinar
February 6, 2018, 3:00 pm-4:30 pm ET**



Logistics for the Webinar

- All lines will be muted during the presentation
- You may use the chat box on your screen to ask a question or leave a comment
 - Note: chat box will not be seen if you are in “full screen” mode
- To participate in a polling question, you will need to exit out of full screen mode
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Facilitator

- **Laurie Hutcheson**, Policy Fellow, National Academy for State Health Policy

Agenda

- Welcome and Introductions
- Overview of the Medicaid Innovation Accelerator Program (IAP) Physical and Mental Health (PMH) Integration Initiative
- Key Principles to Expand Provider Practice Capacity for PMH Integration
- Insights from Two States:
 - New Hampshire
 - Hawai'i

Presenters

- **Melissa Cuerdon**, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services
- **Dr. Benjamin Miller**, Chief Strategy Officer, Well Being Trust
- **Kelley Capuchino**, Senior Policy Analyst, New Hampshire Department of Health and Human Services Division for Behavioral Health
- **Dr. Judy Mohr Peterson**, MED-QUEST Administrator, Hawai'i Medicaid Director

Medicaid IAP: Overview

- A technical support program funded by the Center for Medicare and Medicaid Innovation that is led by and lives in the Center for Medicaid and CHIP Services
- Supports states' Medicaid delivery system reform efforts

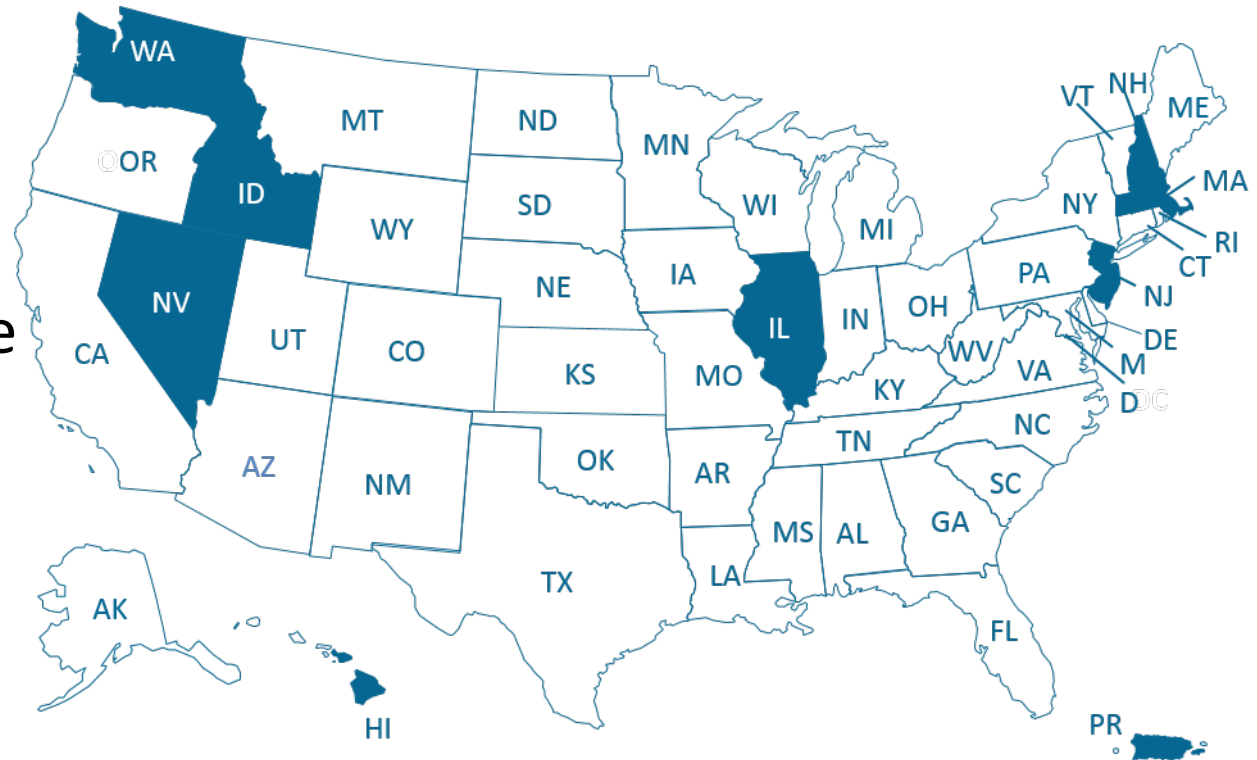


Background

- IAP worked with nine states over twelve months to enhance or expand diverse PMH integration approaches by providing technical support on issues such as:
 - Administrative alignment
 - Payment and delivery system reform
 - Quality measurement
- This webinar is the third in a series of four national dissemination webinars for the IAP PMH Integration program area

Participating Teams

- Idaho
- Illinois
- Hawai'i
- Massachusetts
- New Hampshire
- New Jersey
- Nevada
- Puerto Rico
- Washington



Key Principles to Expand Provider Capacity for PMH Integration

Dr. Benjamin F. Miller,
Chief Strategy Officer,
Well Being Trust

Overview of Presentation

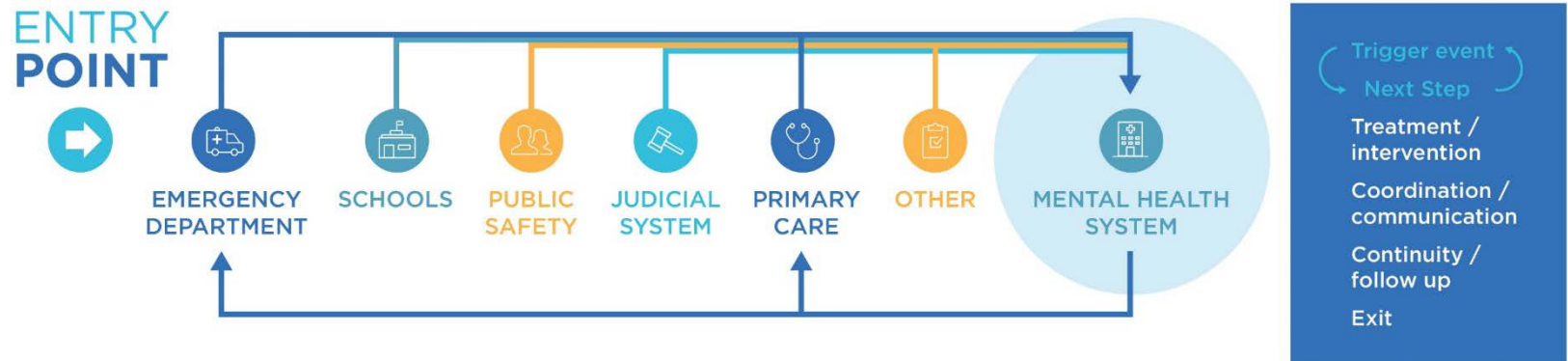
- Context
- Problem and Solutions
- Enhancing Provider Capacity
 - Practice Level
 - Provider Level
- Key Principles for State Policymakers
- Additional Resources

Context for Provider PMH Integration

- Recent report from the Trust for America's Health and the Well Being Trust: Pain in the Nation
- Documents a national crisis in behavioral health:
 - 44.7 million Americans experienced a mental health issue in 2016
 - 20.1 million Americans experienced a substance use disorder
 - 8.2 million experienced both
 - One in five children/teens have had a serious mental health disorder
- [Recommendations for building a National Resilience Strategy](#)

Problem

- Behavioral health issues not identified
- Providers/settings siloed
- Reactive model of care



Solution: Practices and Providers with Capacity to Deliver Integrated Care

- Evidence-based treatment strategies
- Systematic mental health and substance use screening
- Multidisciplinary teams with behavioral health (BH) capacity
- Whole person treatment planning and care coordination
- Commitment to quality improvement
- Electronic health records (EHRs)
- Strong linkages to clinical specialists and social services

Challenge: Infrastructure

Workflow and Access to Care

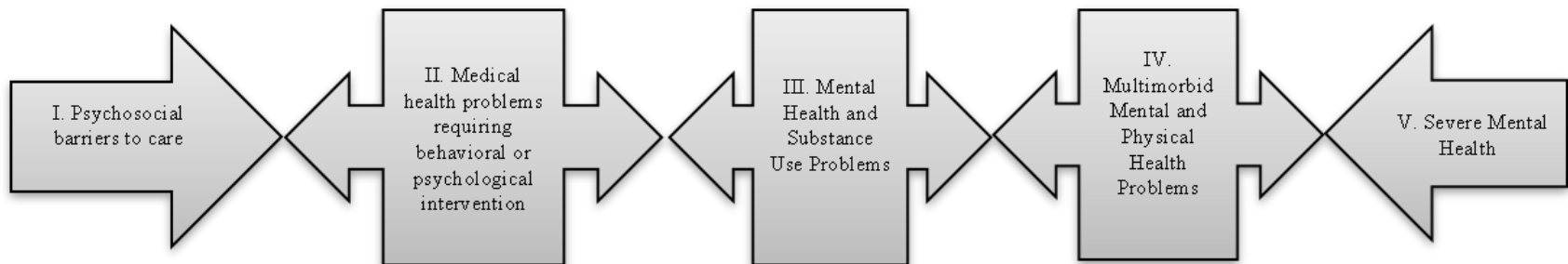
Leadership and Culture Change

Tracking Patients and Using Data

Davis, M., Balasubramanian, B. A., Waller, E., Miller, B. F., Green, L. A., & Cohen, D. J. (2013). Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together. *The Journal of the American Board of Family Medicine*, 26(5), 588-602.

Challenge: Capacity to Address a Range of Needs

To address all aspects of health, integrated primary care practices need the expertise and resources to appropriately treat the full range of presentations:



Miller, B. F., Brown Levey, S., Payne-Murphy, J. C., & Kwan, B. (2014). Outlining the scope of behavioral health practice in integrated primary care: Dispelling the myth of the one-trick mental health pony *Families, Systems & Health*.

One State Solution: Creating Standards for Workforce



A Colorado Consensus Conference:

Establishing Core Competencies for Behavioral
Health Providers Working in Primary Care



Developing and Disseminating Key Provider Competencies

- Colorado convened the Consensus Conference to agree on eight core competencies for BH providers working in primary care
- The 50+ attendees included Colorado's provider organizations, state agencies, and university representatives
- Competency = the knowledge, skills, and attitudes—and their interconnectedness necessary to work effectively in settings

Developing and Disseminating Key Provider Competencies (cont.)

- Revisions to the core set developed were debated and finalized by conference participants the following month
- Plans were developed and discussed regarding how best to disseminate to practices

A Few Principles for State Policymakers

- Enhancing capacity begins with seeing BH as a critical facet of primary care — no different than investments in practice-based care management, measurement and other data use competencies, technology and practice transformation support
- State can be a convener and disseminator/trainer regarding best practices for effective integration

A Few Principles for State Policymakers

- Payments should allow for BH providers to not be trapped in a workflow designed to maximize volume-based payments, or pigeon holed into distinct “physical” and “mental health” coding categories where what they do is limited by set criteria
- Allow for primary care practices to “own” their BH resources and be fully accountable for measured outcomes
- Leverage technologies to augment or enhance BH presence in rural primary care practices

More Resources

- [Make Health Whole](#)
- [Oregon.gov Behavioral Health Collaborative](#)
- [Virginia's Addiction Treatment Services Delivery System Transformation](#)

Thank You!

Dr. Benjamin F. Miller
Chief Strategy Officer
Well Being Trust

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Q&A

Overview of State Strategies to Promote Provider Capacity for PMH Integration

Laurie Hutcheson,
Policy Fellow,
National Academy for State Health Policy

State Strategies to Promote Provider Capacity

State Medicaid programs have a variety of policy levers

- Shift payment away from fee for service toward alternative payment models that facilitate providers adopting key practice elements of PMH integration;
- Using Medicaid state plan and waiver options to support delivery system reform and models that support the care coordination and service components of integrated care;
- Collaborating with public health agencies and state universities to develop/assist with provider practice PMH integration transformation trainings/learning collaboratives.

State Strategies to Promote Provider Capacity (cont.)

- Using managed care contracting to incent Managed Care Organizations (MCOs) to:
 - Promote alternative payment with provider networks;
 - Promote development of standardized quality measurement and effective data reporting/exchange.

Building Provider Capacity for PMH Integration: New Hampshire

Kelley Capuchino,
Senior Policy Analyst,
New Hampshire Department of Health
and Human Services
Division for Behavioral Health

Overview of Presentation

- New Hampshire Context, Background, Goals
- Delivery System Reform Incentive Payment (DSRIP) waiver strategies focused on enhancing provider capacity for PMH integration
 - SAMHSA Clinical Framework
 - Comprehensive Core Assessment Process
 - Health Information Technology
 - Building Workforce Capacity
 - Payment Strategies
- Lessons Learned

New Hampshire Context

- New Hampshire long-standing “whole person” approach to addressing the needs of individuals
- DSRIP waiver program builds on existing initiatives
- Aligns delivery system to better integrate physical and behavioral health care for Medicaid beneficiaries
- Key feature of waiver: Integrated Delivery Networks (IDNs) in all geographic regions of the state to ensure that providers in all areas of the state are engaged in integrated care

New Hampshire Goals

Three core goals of NH DSRIP Waiver:

- Reduction of the number of individuals on the hospital emergency department waitlist;
- Comprehensive and consistent use of a standardized core assessment framework including screening for substance use and depression; and
- Identification of alternative payment models (APM) that align with New Hampshire Building Capacity for Transformation framework, to support the goal of moving 50% of Medicaid Managed Care funding into APM contracts.

Aligned IAP work with existing DSRIP goals and activities

SAMHSA Clinical Framework

SAMHSA Framework:

- All of the primary care and BH provider IDN partners have project and implementation plans to make continued progress along the SAMHSA Framework for Integrated Care
- PCP and IDN partners will be measured on this progress twice each year in six-month increments

Comprehensive Core Standardized Assessment Process

- PCP and BH provider IDN partners participating in NH's DSRIP waiver are employing a Comprehensive Core Standardized Assessment Process
- Assessment incorporates 13 common domain areas in the screening process to integrate medical, behavioral, and social determinants of health
 - Information will be shared among primary, behavioral and social service providers using shared care plans; multidisciplinary team meetings; care coordinators/navigators.

Health Information Technology

Technology investments/strategies include:

- Electronic shared care plan using compatible technology across all IDNs;
- Event notification system for admissions, discharges, and transfers;
- Direct secure message exchange;
- Single statewide data aggregator.

Will support communication across medical, behavioral, and social service providers as progress along the SAMHSA Framework for integration throughout the waiver demonstration period.

Building Workforce Capacity

Initiatives focused on supporting workforce capacity and competency include:

- A statewide workforce taskforce;
- Detailed training plans and curriculums;
- Development of protocols for core standardized assessment, screening and referral, multi-disciplinary team meetings;
- Recruitment and retention incentive payments;
- Legislative Interoperability Committee.

Payment Strategies

Alternative Payment Models (APMs):

- New Hampshire Department of Health and Human Services (DHHS) submitted a high level roadmap to move 50% of Medicaid payments into APMs by December 2020
- Conducting stakeholder meetings with IDN partners to explore provider readiness, existing APM arrangements, and inform the development of our detailed implementation plan
- Also engaging Medicaid MCOs in these discussions in an effort to inform planning process

Lessons Learned

- Funding doesn't eliminate real or perceived barriers.
- Workforce resources remain limited: the same individuals are at every table for multiple initiatives.
- Privacy and data sharing are complex issues: local regulations and provider policies present additional barriers to federal policies.

Q&A

Building Provider Capacity for PMH Integration: Hawai'i

Judy Mohr Peterson, PhD
Medicaid Administrator



Overview of Presentation

- Brief Description of Hawai'i's Health Reform Efforts
- Focus on Physical and Mental Health Integration
- Initiative #1: Homelessness Services
- Initiative #2: Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Initiative #3: Telehealth
- Lessons Learned

Fast Facts

- Medicaid:
 - Serve ~360k or ¼ of state population of 1.4 million and <40% of all children
 - 1115 demonstration waiver since 1994; up for renewal 12/31/2018
 - Medicaid expansion state (including prior to Affordable Care Act)
 - CHIP is a Medicaid expansion (308% Federal Poverty Level)
 - Delivery system is nearly 100% managed care including long term supports & services
 - Mental health managed care carve-out for seriously mentally ill adults with functional need
 - Dental is fee for service; very limited adult dental benefit

'Ohana Nui Project Expansion (HOPE): 1115 Waiver Renewal

Five-year plan to accomplish vision of **healthy families and healthy communities.**

Goals:

- **Triple Aim** (better care, better health, sustainable costs)
- Align a common framework:

“A multigenerational, culturally appropriate approach that invests in children and families over the life-cycle to nurture well-being and **improve individual and population health outcomes.**”

Framework for Innovation



Assuring continued access to health insurance and health care.

Address the social determinants of health.

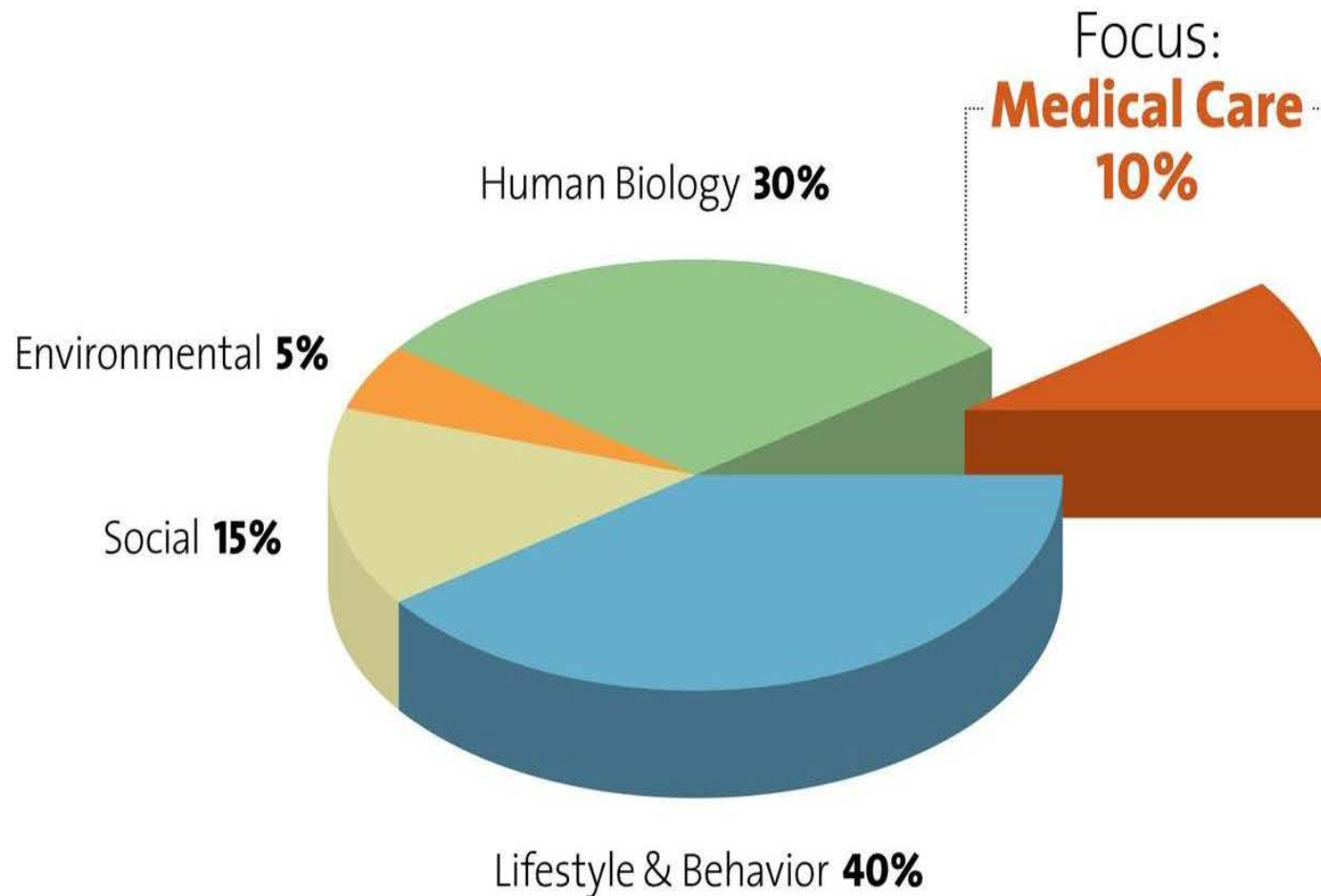
Emphasize whole person and whole family care over the life course.
'Ohana Nui – focus on young children and their families.

Emphasis on health promotion, prevention, primary care, and physical and mental health integration.

Emphasis on investing in system-wide changes.

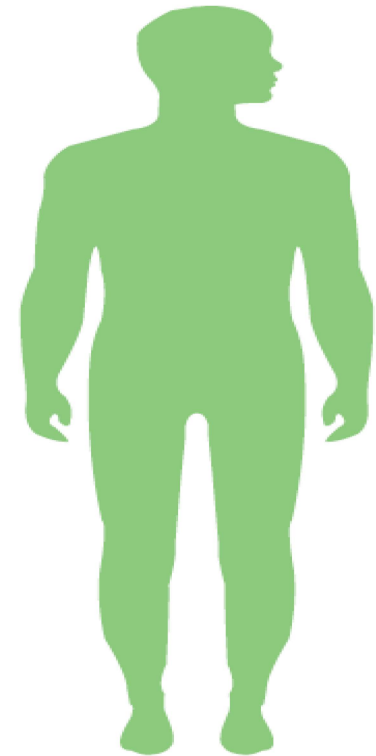
Leverage and support community initiatives.

Framework for Innovation: Social Determinants



Framework for Innovation: Whole Person Health

OPERATES ON THE UNDERSTANDING THAT ALL PARTS OF THE BODY ARE INTERCONNECTED.
ONE PART AFFECTS THE WHOLE, AND ALL PARTS OF THE BODY AFFECT OVERALL HEALTH

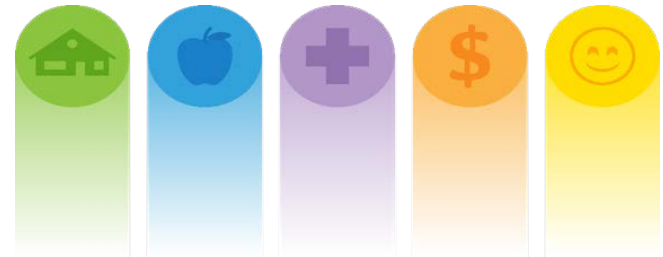


Framework for Innovation: Current System

What? Individual, self-service at various Department of Human Services (DHS) offices located throughout the state

How? Stand-alone programs and services meet individual's needs, one at a time

- Financial assistance
- Food and nutrition
- Housing assistance
- Medical insurance coverage: health and wellness
- Employment training and education
- Child care subsidies



Results: A fractured approach, sets up competing needs; Access and maintenance of benefits correlate to one's ability to navigate process; and fosters inter-generational dependence on the system

Framework for Innovation: 'Ohana Nui

What? A concurrent all-generation philosophy

How? Addressing the needs of the whole family, prioritize needs of children ages 0 – 5

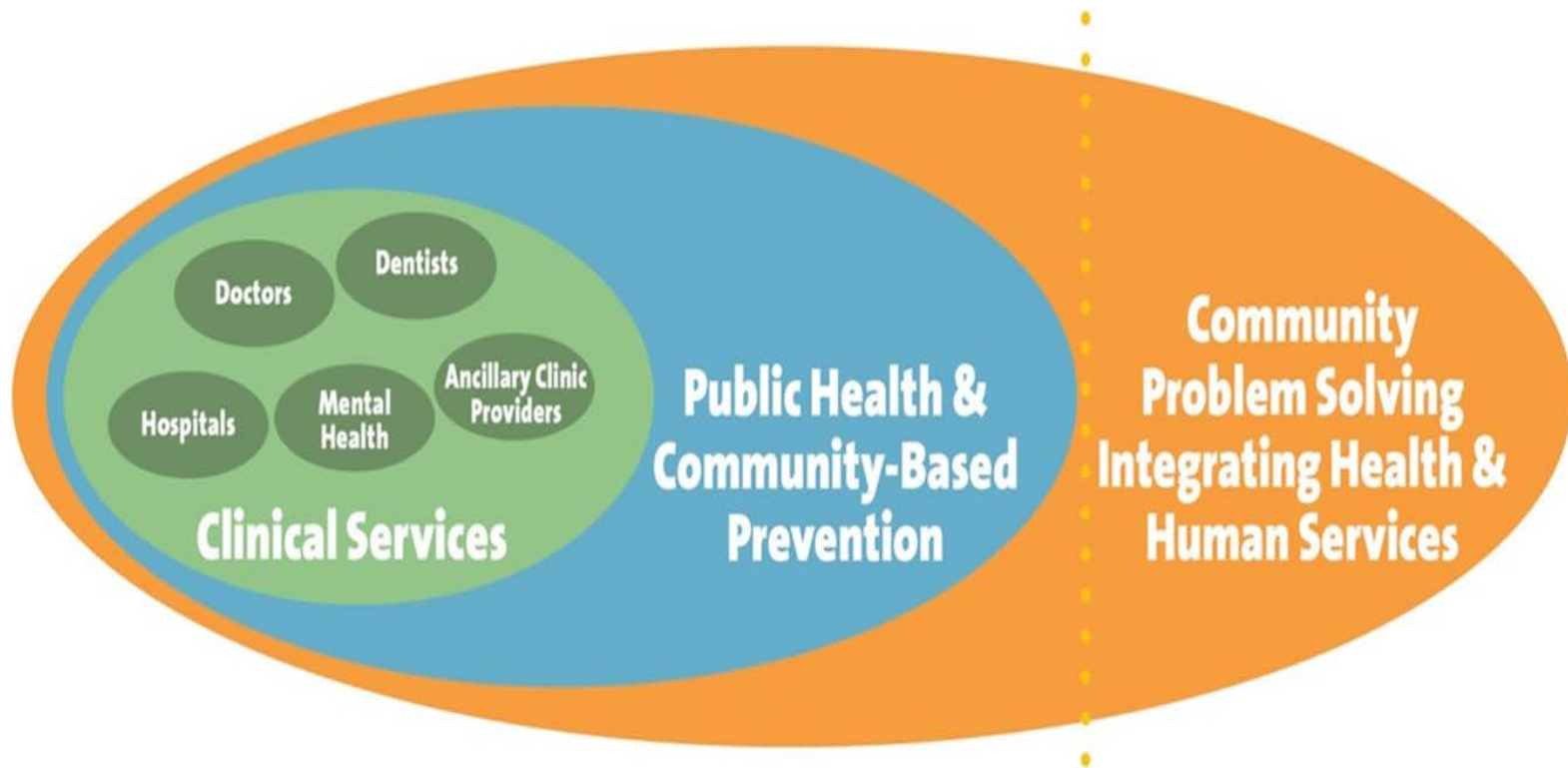
These needs are the social determinants of well-being:

- Housing
- Food/nutrition
- Health/wellness
- Economic self-sufficiency/education
- Social capital



Expected results: Gives them the best chance of breaking the inter-generational cycle of poverty; bends the human services cost curve downward; and increases the efficiency and efficacy of the DHS delivery system.

The Approach Extends Beyond the Clinic Walls



Source: Public Health Institute

HOPE Project Summary

Goals	Healthy Families and Health Communities and Achieving the Triple Aim – Better Health, Better Care, and Sustainable Costs			
Strategies	1. Invest in primary care, prevention, health promotion and PMH integration	2. Improve outcomes for High-Need, High-Cost (HNHC) individuals	3. Payment reform and alignment	4. Support community driven initiatives
Foundational Building Blocks	1. Use health information technology to drive transformation			
	2. Increase workforce capacity			
	3. Performance measurement and evaluation			

Priority Initiative #1: Homelessness

- Why is this a priority?
 - Hawai‘i has the most number of homeless individuals per capita in the country
 - Symptomatic of many different issues that can only be addressed using a comprehensive approach
- How can this be addressed?
 - Family Assessment Center: full range of services in one integrated center.
 - Chronic Homelessness: 1115 Waiver amendment request to CMS for “tenancy supports.” Build up mental health/substance use disorder treatment, intensive case management services to integrate with the tenancy supports.

Priority Initiative #2: SBIRT

- What is it?
 - Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs

Why SBIRT?

- Substance use among pregnant women in Hawai'i is higher than national targets, which reflect there is essentially no acceptable rate of use of these substances. Hawai'i data shows that:
 - 5.9% of women reported drinking alcohol in the last trimester of their pregnancy;
 - 8.6% reported cigarette smoking in the last trimester;
 - 3% reported using illicit drugs during their latest pregnancy.
- Hawai'i ranks among the highest in the nation for excessive drinking rates
- 11.3 % of Native Hawaiians or Pacific Islanders who are 12 years and older abuse or have a substance use disorder

SBIRT- Challenges

- Feedback suggests that many primary care providers (PCPs) are not screening because of a lack of training and resources
- Lack of community level treatment options for individuals with moderate to severe conditions
- Practices in Hawai'i are largely small and independent
 - 64% of PCPs are small practices
- Geographic challenges: island state with maldistribution of resources
 - Shortage of PCPs and BH specialists

SBIRT- Actions and Opportunities

- Partner with Department of Health (DOH) and Maternal and Child Health to train OB/GYNs to screen for SBIRT for pregnant women:
 - MCOs are now paying separately for prenatal SBIRT and follow up counseling;
 - Used One Key Question™ as lead-in for SBIRT.
- Partnered with DOH, Alcohol & Drug Abuse Division (ADAD) to provide SBIRT training and support for federally qualified health centers as a part of Substance Abuse and Mental Health Services Administration (SAMHSA) grant

SBIRT- Actions and Opportunities (cont.)

- Created an SBIRT training quality metric for hospitals (via MCOs):
 - Result: Nearly 100% hospitals trained personnel in SBIRT;
 - SBIRT will become a future pay-for-performance measure for hospitals;
 - Partnered with ADAD and Hospital Association to train hospital personnel.

Priority Initiative #3 - Telehealth

Why?

- Geographic challenges:
 - Hawai'i is an island state with a maldistribution of resources
- Research supports the claims that tele-behavioral health and in-person services yield comparable and cost-effective results
- Allows Hawai'i to efficiently and effectively use scarce resources
- A method to address the severe provider shortage, especially for psychiatrists and other BH providers

Telehealth - Successes

- Act 159 (2014) requires providers to be reimbursed for interactive audio-video sessions at the same rate as face-to-face services. This includes PCPs and mental health providers.
- Act 226 (2016) improved access to telehealth by:
 - Requiring MCOs to pay for services;
 - Removed geographic limitations;
 - Included additional modalities such as live consultation and mobile health;
 - Allowed telehealth services to originate in a patient's home or other non-medical environment.

Telehealth - Opportunities

- The Child and Adolescent Mental Health Division (CAMHD) began using telehealth to:
 - Provide tele-psychiatric care to support children on neighbor islands;
 - Conduct mental health assessments;
 - Provide care coordination.
- In the future, telehealth will be used to connect youth housed in residential facilities with their families.

Telehealth – Opportunities (cont.)

- Require MCOs to move toward more sophisticated value-based purchasing that supports appropriate utilization of telehealth and tele-psychiatric services
- Collaborate with various entities to support the infrastructure needs to expand the use of tele-psychiatry and telehealth in general

Other Provider Capacity Opportunities for Hawai'i

- Plan/develop community care teams to support care coordination and linkages to community resources
- Require MCOs to move forward with more sophisticated value-based purchasing
- Plan pay-for-performance model to include more BH metrics
- Payment to PCPs for using the Collaborative Care Model
- Support PCPs by promoting psychiatric hotline services (aka “curbside consults” adult/pediatric) and Project Extension for Community Healthcare Outcomes (ECHO)
- Incorporate health-related social needs into provider and insurance payments

Lessons Learned

- Partnerships are key!
 - Relationships matter
 - Need to move beyond “traditional” partners
- Things take time
- Focus on the population health needs of the community
- Must have excellent understanding of your delivery system, including mental health and substance use delivery systems
- Payment systems need to evolve with the delivery system, which can be very challenging!

Thank You!

Judy Mohr Peterson, PhD
Medicaid Administrator

jmohrpeterson@dhs.hawaii.gov

Q&A

Key Takeaways

- Providers face challenges in integrating physical and mental health services:
 - Changing practice culture;
 - Ensuring workforce competency;
 - Adding processes to enable care coordination;
 - Making wholesale infrastructure changes to enable data use/sharing.

But it is the best way to achieve “whole person” care.

Key Takeaways (cont.)

- The good news- States' tools to support providers:
 - Medicaid state plan/waiver authorities;
 - As a payer;
 - Convening/partnering with other state agencies and organizations;
 - Ongoing role in supporting workforce capacity (e.g. standard assessments and trainings) and HIT capacity (e.g. data use/exchange, telehealth);
 - Relationship building is critical to help change how BH and primary care clinicians interact;
 - Continue focus on shifting payment systems to support PMH integration.

Upcoming IAP PMH Activities

National Dissemination Webinar	Date
Administrative and Reimbursement Strategies	March 26, 2018

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[Pop-up Evaluation]

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 - SOTA email list
 - IAP email list
 - NASHP newsletter
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2. The overall substance and quality of the webinar were excellent.
 - [rate from Strongly Agree to Strongly Disagree]
3. The level of detail and the content were adequate and useful to me.
 - [rate from Strongly Agree to Strongly Disagree]
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 - [yes/no]
 - If yes, how?
6. What did you find most valuable about this webinar?
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