Pennsylvania Enrollment Services Webinar Series
Physical & Behavioral Collaboration
January 25, 2017

MAURICIO CONDE: Good morning everyone, my name is Mauricio Conde. Welcome to the Pennsylvania Enrollment Services Webinar Series. Today's webinar is titled: Physical & Behavioral Health Collaboration. Thank you for attending.

Before we begin, please know that if you have any questions, you may type them directly into the chat box at the bottom left of your screen, and we'll answer them at the end of the presentation. The slides and other related materials will be posted on enrollnow.net and we will be sending the slides and a link to the recording to all attendees after the webinar.

Our presenter today is Dr. Dale Adair. Dr. Adair is the Medical Director and Chief Psychiatric Officer for the Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS).

Dr. Adair consults on many major initiatives, including the State Innovation Model, Pennsylvania's Behavioral Health-Physical Health Integration efforts, Pennsylvania's Governor's Advisory Council on Veteran's Services and the Joint State Government Commission Advisory Committee on Opioid Addiction. Dr. Adair also serves as a consultant for the Center for Medicare and Medicaid Services on hospital standards. Dr. Adair is board certified in Psychiatry and is a Fellow of the American Psychiatric Association. Without further ado, I am going to turn it over to Dr. Adair.

DR. DALE ADAIR: Good morning and Mauricio, thank you for the introduction and the opportunity to come in and present on the activities that are currently underway in the Department of Human Services. I am going to apologize to everyone in advance because since the New Year rolled in, I have been dealing with a cough and during this presentation you will hear that at some point so I apologize for the disruption that will cause.

The plan is to take us to approximately 11:40 that will then give opportunity to ask questions for 10-15 minutes. I will try to stay on that timeline. You can see from the presentation that there are a bunch of slides. When we put the presentation together a while ago, we were all inclusive and I will not talk about every slide but when you receive the presentation, you will have the entire presentation. The entire presentation would take about 2 hours.

Anyone who has seen me present, should be aware that I use a lot of cartoons in my presentation because I feel humor is very important and that we do not get enough of it. You should all be able to read the caption "I hope you are taking into account that I have an enormous ego"

I plan on talking about Integrated Care Plans (ICP), which is a project that the department rolled out in 2016, Certified Community Behavioral Health Clinics (CCBHC), Centers of Excellence (COE's) and then we will finish up talking about the Agency for Healthcare Research and Quality (AHRQ), which is a 3 year grant we received in September. So those are the things that I plan on covering.

The ICP, one of the things that there has been a large focus within the department has been in assuring that we are looking and caring for the entire person. The focus is on integrating behavioral health, which is what MAXIMUS wanted me to talk about. The focus of the plans is really on the integrated care for individuals who are dealing with serious and persistent illness along with substance abuse as well as

mental health concerns. This builds on a pilot done in the south east and south west. Through this, the behavioral health and physical health plans are expected to work together for the overall improvement in outcomes for the individuals that are their recipients. The departments both of the Office of Mental Health and Office of Medical Assistance allocated $10 million each for this program and you will see later on how that is going to work and how they will be able to earn the money. Some key points, we have found through other studies is that when we look at physical health stays and hospital stays, that roughly 39% of those individuals that were looked at had a primary mental health diagnosis within one year. With readmissions, we saw an individual who had a chronic mental health illness and had a behavioral health condition were more likely to be re-admitted and individuals who have both mental health and substance abuse challenges were even readmitted at a higher rate. All of those things lead us to believe and to reinforce the need for us to address to the care of the entire person, that we should not just focusing on the head if you would without focusing on the rest of the body. My colleague in all this, Dr. Kelley, is fond to say sometimes we tend to forget that the head is connected to the rest of the body and the Integrated Care Plans as well as a lot of the other work that we are doing really reinforces that we should be treating the whole person. So, hopefully as we go through this, that is the consistent message that you will end up hearing.

The process activities and there is further details on this on some of the other side, the plans were to stratify their membership, they were to develop a joint behavioral health/physical health integrated care plan for 500 but this ended up being a little different because things are a little more complicated on the behavioral health side. The department on the physical health side directly contracts with the managed care plans, whereas on the behavioral health side, the contracts are generally through the counties so it ended up being a little different there but those process activities for them to have integrated care plans, for them to do member stratification and for hospital notification, so if someone were admitted on either side, whether it was physical health or behavioral health, they are really required to notify their counterpart that the individual was admitted. Then there are 5 performance measures which I will talk about a little later. In the member stratification, really the initial baseline was done, the physical health plans did an initial stratification and they were really based on one of the prior pilots that we had done, it could be divided into 4 boxes – high physical health/high behavioral health needs all the way down to low physical health/low behavioral needs and really what we found was that the plans really looked to work together in this stratification. In the hospital notification, again, the physical health-behavioral health MCO's have a joint responsibility for notifying each other of the hospital admission and coordinate discharge and follow-up and that really is the big piece of this and that notification had to occur within 1 business day of when the MCO learned that the individual had been admitted. The expectation was that they would be able to do this at a 90% rate. The 500 members would have an integrated care plan and that was at a minimum, a lot of the plans actually have done a lot more than what we has asked as the minimum in this and being able to share that information and I will admit that we had some initial challenges with the sharing of information, but for the most part, the plans have been able to work through that. The performance measures that we have, the first one is initiation and engagement, which is important because we now that a lot of individuals who are challenged with substance use disorders, part of our challenge is getting them initiated in treatment and then having them remain engaged so this is a big focus on this and later on

there are some slides that actually show where we were looking for incremental improvement. The second one is adherence to antipsychotic medications for individuals with Schizophrenia. We know that in PA, we are a little shy of 70% adherence to antipsychotics of individuals who have a diagnoses of Schizophrenia. And then the third one is combined physical health/behavioral health, inpatient 30 day re-admission rate for individuals with Serious Persistent Mental Illness (SPMI). Emergency room utilization for individuals with SPMI and then a combined physical health/behavioral health inpatient admission utilization for those individuals with SPMI. So these are the 5 performance measures that we have utilized as part of this. Again, the Office of Mental Health and the Office of Medical Assistance each contributed to a pot of $20 million so we each put in $10 million and the plans are able to earn that money based on improved outcomes. So there is a baseline that is established and then we are looking for incremental improvement. One of the questions I had asked as we had gone around the state talking about this is where we are taking money away and no, there is no takeback as part of this, it is just money that could be earned. And on the behavioral health side, again it was, because the contracts are with the county, the counties actually earn the percentage and the counties actually then also worked with the plans so that the plans actually were able to earn a certain percentage of the money as well. Ultimately the plans will tell you, the counties will tell you, that to implement change in these numbers it really comes down to the providers and the work that the providers do. Some of the counties actually worked it that some of the money actually was pushed down to the provider level. And ultimately this was a beginning step for us but ultimately that really is where we believe that the money should be pushed towards because that's really where most of the work will end up being done to actually get those changes. The 5 performance measures are equally weighted at 20%, the initiation/engagement, because there are two parts to it, the initiation is 10% and the engagement is 10% but all others are at 20%. This shows you for example how it would pay out. If for measures 1, 2 and 3, if the percent improvement was anywhere from .5% to slightly less than 1%, they would earn 50% of the money allotted for that, and on up to if it were greater than 3 percentage points improvement, they would earn the entire 20% that they were eligible to earn for those two. For measure 4 and 5, 100% payout will be made if there was a reduction of 3 or less events per 1,000 member months and a 75% payout if there was a reduction of 2 or less events per 1,000 member months. So that has gone on, I am going to have to think about what that actually says. This has been going on. We have received out first reports back from the plans and that has been analyzed by both the quality folks at OMAP as well as at OMHSAS and there are discussions between the two offices on what we need to do to further improve this program so there is going to be more to come on this and the plans that are on the phone, you will be hearing more about that as well. So, that is the ICP or integrated care plan.

The Certified Community Behavioral Health Clinics, so this was an opportunity that we really have been working on for the last couple of years because this started off with us having to apply for a planning grant. If I can give some background information, most of you are aware that there had not been really any substantial changes in the way community mental health has been divided since probably the mid-60's, early 60's since JFK was in office. Although there have been a lot of calls for mental health reform and a need to change a number of different structures in how outpatient treatment is provided, there really had not been any movement until the PAMA, Protecting Access to Medicare Act, was enacted in 2014. This enabled the Secretary of Health and Human Services to start the process for this and so

initially what we did was , we applied for a planning grant which we received and we were one of 24 states to receive that planning grant and then at the end of the year and that was last year, was actually that was in 2015, October of 2015 we were awarded the planning grant and when you receive the planning grant, you were obligated to do certain things which included involving stakeholders in working through this process on how you would go about certifying a clinic and then in the end you had to apply to become a demonstration state. So I think that some of these slides talk about this. So the goal of the Certified Community Behavioral Health Clinics really is to improve the quality of care and a large part of that is on a focus of evidence based practices. Most of the administrators of outpatient clinics will tell you that the payment structure also needed to change because there were times when they either could not provide something or they were attempting to provide something or would provide something they were not really paid for. So that is all part of the planning. And then, again in the end, it is to become a demonstration state and the SAMHSA was only providing, they were only giving out 8 demonstrations. This slide shows you the 24 states that were part of the planning grant, were awarded the planning grants and you can see it was widely dispersed across the country, although up in, I don't know if they can see, can they see my, so you will see that there is a large grouping right here, right here and right here and in this area, not so much. I can't tell you whether or not if they applied and did not receive the planning grant or not. So with the planning grant, we went through the process we have a steering committee but there really were four focuses and we followed the federal model, one of which was on the certification, one on the consumer engagement and involvement, the PPS, which is the payment structure, Prospective Payment System is what it stands for and one on data collection. We worked through all of these during the past year. We actually sent out a letter of interest to see how many clinics were interested in becoming a CCBHC, and I will tell you that when we looked at the numbers, there really were a total of 300 potential across the state, and 75 sent in letters and then from that 75, when we actually asked the clinics which ones were truly interested in going forward in submitting applications to go forward, there were 16, and they were in a, not in the entire state but in a diverse part of the state. Here in the South East, in Allegheny County, but the grant required, the planning grant required in order to be a demonstration, you really had to also have a diverse demographic diversity in your clinic, so you had to have at least one that was rural area and at a minimum, you had to have 2 clinics to go forward. So at one point we had 16. Some of the program requirements were around staffing, availability and access of services, care coordination, scope of services, organizational governance and accreditation. In the governance piece those of you involved in FQHC's, Federally Qualified Health Centers, will be aware. There was a requirement that these clinics, their governance would be comprised of at least 51% of consumers or family members and if they could not do that, that they had to have a way of substantially getting the input from those individuals.

The scope of services, there are 9 services that are really required as a part of this. One is crisis, the screening assessment diagnosis, risk management, patient centered treatment planning, outpatient Mental Health and Substance Use services are the 4 that the clinics themselves would have to do and then the others, the clinics could enter into agreements with what are called Designated Care Organizations (DCO's) to provide. The important thing here well, all of this is important, but family, peer support, patient centered, focus on substance use services and particularly their 73 criteria they had to meet in order to be certified. One of those is that all the clinics have to have someone on their part of

their staff who provides Burprenorphine treatment so there is a big focus on opioid addiction and opioid dependence and its treatment. That is something I predict we are going to see more and more within the mental health clinics including those that are not part of the CCBHC's. Focus on quality and clinical outcomes. I am paying attention to my time and as usual, time flies. What we ended up doing was, we ended up certifying 10 clinics and this list of the counties where the clinics are. From this, you will note we have, I think 4 of our 10 clinics are considered in rural areas so we very easily met the requirement of having at least one. So we think that we were well positioned and SAMSHA and their experts who reviewed the applications, because we sent in our application in October, agreed with us. We were awarded, we found out on December 21,, 2016, so it was my Christmas present that we were awarded as a demonstration state. So our plan at this point is to implement July 1, 2017. Originally the feds said that they would notify the states in December and the expectation was that you would implement in January and obviously that does not leave any time to do anything so with input from the states and from others, they ended up changing that and gave the states the option of implementing anywhere between January and July and I believe all 8 states plan on implementing in July. So we will implement July 1st. We continue to work with the clinics to get ready for the implantation. The prospective payment system has been developed and worked out and 2017 will be an exciting time and as I said this is a two year demonstration and at the end of the two years, we will be able to, the feds are doing an evaluation of the program, which is due, a report is due to Congress in 2021 and then they will make some decisions based on those outcomes. We, the state of PA, DHS specifically, will also be doing our own evaluation of the program as we go along. I should point out that one of things with the prospective payment system allowed us do was to give a quality bonus to the clinics. So there are 6 measures, performance measures that they have to submit data on. We are currently in the first 6 months of this year and we are collecting baseline and again as with the ICP, we are looking at incremental improvement. They will be able to earn a bonus based on those outcomes. The clinics are excited about the opportunity and we are excited about the opportunity.

So Opiate Use Disorders and I am going to leave you with a lot of these slides because I need to move on. But we know that in PA as well as the rest of the country, that we have a severe problem with deaths related to opioid use and heroin, so prescription drugs and heroine being the opiate. The program that we have rolled out, and there are a number of different strategies for opioid use, but we have rolled out the COEs, let me skip. So basically the governor's budget, 2016/2017 budget included $15 million in state funds to expand access for treatment. We are looking to expand that treatment to over 11,000 individuals through the Centers of Excellence. We started off with 20 COE's, which were primarily, were all on the behavioral health side and were licensed by the Department of Drug and Alcohol Programs. And then we also, I think it was in August or September, we would announce another 25 clinics, that 19 of which are essentially going to be managed through physical health HealthChoices Program and they will be providing treatment with Burprenorphine and Naltrexone. In the other 6 are on the behavioral health, will be managed through the behavioral health HealthChoices Program. They are, I don't believe I have a slide that shows where they are located but the clinics are set in a diverse area across the state but we focused on areas where the opioid deaths were high, was one of the factors we utilized. The COE's will each receive $500,000 to deploy community based care management team. There are outcomes that are being tracked and the expectation is to provide high quality

treatment. Individuals will receive MAT and those that are not receiving care through a COE that is related, that is licensed by Drug and Alcohol will be referring individuals for the other counseling and supportive services that they need but it really is to make sure that individuals get what they need so the care management teams will be helping to make sure that people get connected, whether it is for mental health needs or physical health needs.

On the care management teams, again, you are going to have these slides and then there is a whole host of metrics that we will be following and they will be reporting and there is an outcomes survey that will be done and looking at hopefully capturing the recovery that people go through. That is a quick piece of the quality metrics and I know that I am flying through this. This is self-reported 15 question survey that I talked about. The other piece that I should mention is that all of the COE's are expected to participate in a learning network, learning collaborative and we believe that a lot of the clinics are doing really, really good work. A learning collaborative will give everyone an opportunity to share best practices and to improve the overall outcomes, again for those individuals that we are all interested in ensuring that they receive the best treatment. That is, the payment did not go out in one lump sum, it went out in 2 splits.

So, you know what, there is not a slide here on the AHRQ. So I will talk about the AHRQ without looking at a slide. So the AHRQ grant, the Agency for Healthcare Research and Quality. PA received a, in September, we received an award that is a total of slightly less than $3 million, so it is $1 million per year for 3 years. We are partnering with the University of Pittsburgh and with the COE's will be involved in this so there is a lot of interconnectedness between what I have already talked about. The focus with that grant is on rural areas so and to increase the quality of MAT that is provided in rural PA. So what we had told AHRQ that we would do is we want to recruit and train 25 practices in rural PA, specifically there are 23 counties, most of which are kind of in the I-80 corridor and we want to bring in 75 practitioners. So, they will, they are being recruited, they will be trained in MAT and how it will fit into their workforce. We are looking at a number of factors, we looked at barriers why people, why physicians in general do not, have not gotten involved in treating individuals with MAT, particularly Burprenorphine. And I should say that when we talk about MAT when it comes to the AHRQ grant, we are talking specifically about Burprenorphine and possibly Naltrexone, but is primarily going to be Burprenorphine. The focus again is not just on the medication, although the training really is, part of the training is focused on how you provide high quality treatment with MAT, the medication piece but also the connection with the other supports. And for the primary care practices that we recruit and become part of this, they will have support, Dr. Adam Gordon, who is with the University of Pittsburgh will be doing training and we will also have the University of Pittsburgh Medical Center/Western Psychiatric Institute and Clinic, there is a telepsychiatry model that we will be utilizing. Those of you who are familiar with the ECHEL model which came out of New Mexico, it is similar but not exactly the same thing but the focus is on, there will be a focus on case learning and if one of these providers has a case that they are challenged by, they will be able to call in and speak with one of the addiction psychiatrists at Western Psych to, for some consultation and advice on how to manage a case. So it is a very, very rewarding and a great time to be working within the Department of Human Services here in PA. There is a lot going on in this space and we are very happy about all of the interest that we have had on these variety of projects. I could actually talk about each one of these, probably for an hour but I tried to cover 4 things within 40-45 minutes, so I apologize that I did not get into as much detail as you would.

But the, I would tell you that the CCBHC application, if you were interested in that is actually on the DHS website. There is also a website for the AHRQ grant. That I believe is linked to the DHS website as well. And with the AHRQ grant there were only 4 of those awards given out so you know Pennsylvania, we have done a lot of good work in the past year and will continue to strive to improve things for the individuals who we care for.

So with that, I will turn it back over to Maurice.

MAURICIO CONDE: Thank you so much Dr. Adair. By the way, before we end if you have any questions, you can type them in and we will respond to the questions and if you don't get your answer at this point or you don't ask the questions, please send us an email at **mauricioconde@maximus.com** and we will make sure that we get you an answer. The presentation will be located at enrollnow.net and after this meeting there will be a survey for you to take and also there will be a link to the materials. The materials will be posted on the website likely this afternoon and we will appreciate your feedback.

MAURICIO CONDE: There is a question right now for Dr. Adair.

MAURICIO CONDE: Will the data reported to DHS by the Centers of Health Excellency also be reported to the managed care organizations and will there be limitations of this data elements and will they be shared with the managed care organizations?

Dr. DALE ADAIR: Hi Nick, excellent question and this is an area that we have continued to have further discussion about. So there have been some concerns expressed about who we share certain data with so we continue to look at it so there's going to be more to come on that so I can't give you a definitive answer currently. But because some of the questions that have been raised about it, we have decided to take a harder look about what we will be able to share. We will be sharing that information with the MCO's as we move forward.

MAURICIO CONDE: And I think that the other piece, will there be limitations of the data?

DR. DALE ADAIR: Well I think I answered that within my answer to the question. This has come up and we have continued to explore it.

MAURICIO CONDE: Okay, there is another question and the question is:

MAURICIO CONDE: My question and strings concern centers around what and whether a patient consumer's information is shared with life insurance companies.

DR. DALE ADAIR: This has nothing to do with life insurance companies. We have, I am not aware of any interaction that DHS has with life insurance so, I would not imagine that we are sharing anything with the life insurance companies.

MAURICIO CONDE: Okay, it doesn't seem that we have any more questions. So again, thank you so much Dr. Adair for participating. Just as a reminder, if you go to enrollnow.net, you will also have information about the upcoming HealthChoices consumer advisory committee meetings and the upcoming webinars that will be scheduled. The next one is for March 29, 2017 at 11:00am Eastern Time and the topic will be the Department of Human Services Medical Assistance Transportation Program.

Thank you so much Dr. Adair.

DR. ADAIR: Thank you

MAURICIO: Thank you and at this point, the meeting will end. Thank you.