

CYBHWG Behavioral Health Integration subgroup

**Monday, May 3, 2021
10:00 am – Noon**

| Action Items | | | | | |
|--------------|--|--------------------------|----------------|-----------|--------|
| # | Action Item | Assigned To: | Date Assigned: | Date Due: | Status |
| 1 | Schedule future subgroup meetings | Co-leads & HCA staff | 5/3 | | |
| 2 | Arrange FAST presentation for future meeting with Nat and Erin | Co-leads | 5/3 | | |
| 3 | Share regional breakdown for performance measure data | Alice Lind, Rachel Burke | 5/3 | | |

| Agenda Items | Notes |
|--|---|
| <p>Children & Youth BH Disaster Response Update</p> <p>MaryAnne Lindeblad, Medicaid Director</p> | <p>See page 4 for DOH proposal.</p> <ul style="list-style-type: none"> Lots of great investments from legislative session. Health Care Authority (HCA), Department of Health (DOH), Office of Superintendent of Public Instruction (OSPI), and the Department of Children, Youth and Families (DCYF) are working together closely to respond to the executive order regarding the youth mental health crisis. Just beginning this work; not included in budget, so looking at what \$ might be available. |
| <p>Behavioral Health Utilization information – Milliman</p> <p>Alice Lind & Teresa Claycamp, Health Care Authority</p> | <p>See page 6 for slides, followed by a regional breakdown of performance measures and Milliman’s actuarial memo.</p> <ul style="list-style-type: none"> Note: The slides have been updated to address some of the questions at the meeting. 2 rates – physical health package; behavioral health package Physical health includes the benefits that are traditionally in the Apple Health BH benefits only those that were previously in the BHOs (small number). We at HCA see it as a blended benefit – still comes as two separate chunks of money in rate setting process. Hoping over time it will be one integrated rate. |
| <p>Clinical Integration</p> <p>Colette Rush, Health Care Authority</p> | <p>See page 33 for slides; see page 55 for a list of partners involved in this work.</p> <p>Introduction to the work of the Clinical Integration Assessment Tool Work Group</p> <ul style="list-style-type: none"> To advance integration, need for a common language and statewide assessment tool that works for physical and behavioral health. Necessary to be able to compare data and set benchmarks statewide Tool selected was developed by New York State see page 40 for links). Ultimate goal is to develop strategic framework to implement this work, one that helps outcomes Universal screening key to this work |
| Agenda Items | Notes |

| | |
|---|--|
| <p>BH Integration at Pediatrics Northwest</p> <p>Mary Ann Woodruff, Pediatrics Northwest</p> <p>Joe Le Roy & Wendy Pringle, Hope Sparks</p> | <p>See page 57 for slides.</p> <p>Bridge of Hope: Behavioral health integration at the pediatric medical home</p> <ul style="list-style-type: none"> • Average number of calls a family must make to receive behavioral health care: 26. Average number of calls with this process: 0 – we provide care at the clinic and refer to specialty care as needed. • Focus on connecting children and youth with mild to moderate behavioral health issues to care, reducing the number of children and youth that need more intensive care. • Reversing the current model of “pipeline to crisis services” • Universal screening and identification of mild to moderate BH needs in primary care. • Birth to age 3 strategy (page 74). • Ages 4-21: Collaborative care model (page 76). Working with AIMS and implementing to fidelity, • Collaborative care team: Pediatrician, BH care manager (clinician), and psychiatric consultant. • Registry tracks engagement and progress • Previously it had taken an average of 26 calls to get a child into BH care; in collaborative care, there are 0 calls. Rather, the team takes responsibility for setting up BH care that is needed • Stepped care – will refer if child/youth needs specialty care • Most billing done through collaborative care codes rather than psychotherapy codes. • Start-up costs were grant funded. • Job satisfaction is improving with this model for both PCP’s and BHP’s because they see kids improving • Sustainability is challenging |
| <p>Next Steps</p> | <p>Additional presentations re what exists and is available to support BHI currently:</p> <ul style="list-style-type: none"> • Other BHI programs • MCO’s • Carriers for commercially insured • FAST – First Approach Skills Training - time limited, evidence based interventionsHCA <p>Addressing the challenges of setting up pediatric BHI programs and possible solutions:</p> <ul style="list-style-type: none"> • Role of trained navigators as service extenders in primary care and as coordinators with other providers to kids, including schools, ED’s/hospitals, and specialty care clinics, and to support evidence based interventions such as Triple P or depression/anxiety strategies. • Start-up costs – what is needed, what are options for funding • Sustainability – use of collaborative care codes other payment options and ways that rates can support the work of integration, including care management • How to ensure that programs are evidence based, outcome-driven <p>Recommendations for action (TBD)</p> <p>Timeline</p> <ul style="list-style-type: none"> • Likely will need two meetings in June, July and August • September deadline for draft recommendations • October deadline for final recommendations |

| | |
|--|----------------------------------|
| | See page 91 for edited Chat log. |
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Attendees

Rachel Burke, Health Care Authority (HCA)
Representative Lisa Callan, Washington State House of Representatives
Dr. Phyllis Cavens, Pediatrician
Teresa Claycamp, HCA
Victoria Evans, Molina Healthcare
Dr. Thatcher Felt, Yakima Valley Farm Workers Clinic
Sylvia Gil, Community Health Plans of Washington (CHPW)
Leslie Graham, Seattle Children's
Kimberly Harris, HCA
Libby Hein, Molina Healthcare
Dr. Robert Hilt, Seattle Children's
Kristin Houser, Parent advocate
Avreayl Jacobson, King County Behavioral Health and Recovery
Nichole Jensen, Department of Social and Health Services
Nat Jungbluth, Seattle Children's
Joe Le Roy, Hope Sparks

Alice Lind, HCA
MaryAnne Lindeblad, HCA
Laurie Lippold, Partners for Our Children
Dr. Sheryl Morelli, Seattle Children's
Deborah Pineda
Dr. Jennifer Polley, Pediatrics NW
Wendy Pringle, Hope Sparks
Sarah Rafton, Washington Chapter of the American Academy of Pediatricians (WCAAP)
Kimberley Robbins
Colette Rush, HCA
Caitlin Safford, Amerigroup
Tatiana Sarkhosh, WCAAP
Danial Smith, CHPW
Mary Stone-Smith, Catholic Community Services of Western Washington
Erica Torres, Peace Health
Mary Ann Woodruff, Pediatrics NW
Jackie Yee, ESD 113

**Youth Behavioral Health Crisis
Framework for an Emergency Response
April 2021**

The following is a proposed framework that can support a conversation on how all partners can work together to address the surge in youth behavioral health needs as a result of the impacts of COVID. The framework proposes some statewide activities and supports with connection to nine regional response initiatives.

The DOH COVID-19 Behavioral Health Group, in consultation with the Northwest Healthcare Response Network and its Inpatient and Outpatient Youth Behavioral Health Surge Workgroups recommends modeling the organization of the response after [Kids' Mental Health – Pierce County](#). Each of the nine ESD/BH-ASO/ACH regions in the state, including Pierce, would stand up Kid's Mental Health Emergency Response structure, with support and help from state partners.

Objective 1: Improve coordination and allocation of inpatient psychiatric beds

1. Convene BH hospitals to design and implement daily huddle
2. Create process for EDs and others to confirm placements for youth boarding in ERs: provide a process for Regional Multi-Disciplinary Teams (MDTs) to interact with BH hospitals daily.
3. Track the queue of youth waiting for IP placements, boarding in EDs

Create MDT Huddles in all regions goal of MDT involvement in this process to help identify resources that could take a youth off the queue – that is, find them alternative treatment as an outpatient; this would especially apply to youth in the queue who are in line for a repeat hospitalization (and even more especially for rapid re-admits)

4. Create MDT Huddles in each of the nine regions to provide rapid response for youth in the queue for inpatient services and to explore with the decision makers from local organizations other alternative plans of care for a youth/family especially those with previous IP stays or facing a rapid readmission. The goal of the MDT is to address the needs of youth in the queue and reduce the number of youth waiting in the queue for appropriate placement.

Statewide Huddle: DOH/HCA with support from BH Surge Management Contractor.

Regional MDT Huddles: Regional Response Teams convene and support with BH Navigator and BH Response Coordinator support.

Objective 2: Reduce demand for Inpatient Psychiatric Beds

1. Expand Seattle Children's Crisis Consultation Clinics to all regions
 - a. Add an additional team to Seattle Children's Crisis consultation Clinic that can serve youth with suicidal ideation in person or virtually.
 - b. Train local crisis consultation clinics to stand up in each (9) region.
 - c. Train regional Behavioral Health Navigator to manage transition of youth back to community.

Seattle Children's Crisis Consultation Clinic in cooperation with BH Navigators and regional response teams.

2. Train regional partners in Youth Crisis Management
 - a. Offer training in all regions to any ED staff, PCPs, School staff and parents based on curriculum developed and tested by Seattle Children's.
 - b. Local regional response structure can recruit candidates for this training
 - c. Trained personnel equipped to assist youth in crisis and potentially help avoid overuse of the ED or escalation of crisis.
3. Train MCOs on use of "in lieu of" option to refer youth to Intensive Outpatient Treatment as appropriate
4. HCA, DCYF, DSHS and DOH explore solutions for hard to place youth to improve throughput especially at Seattle Children's

Objective 3: Expand workforce by recruiting graduate students and retirees

1. DOH BH Group can coordinate use of the COVID Response Volunteer Management System and process
2. Regional response teams can help recruit volunteers in coordination with DOH

Objective 4: Train volunteers and students in TF-CBT.

Objective 5: Identify and refer youth for stepped care interventions (schools and pediatrician's offices)

1. DOH offers triage tool, PsySTART Pediatric to all schools and partners who want to use it.
2. OSPI/ESDs and school districts identify and triage youth at risk (MTSS or Sonoma Model)
3. Schools coordinate referrals of youth to Response Coordination Team for CBT sessions or MDT huddles as appropriate.
4. Primary care providers and Pediatricians refer youth to Response Teams for CBT sessions or MDT huddles as appropriate.

This framework assumes that the schools will triage and identify students. The schools and ESDs have staff and resources to coordinate the referral of students to appropriate supports whether they are available in the schools or accessed through the Regional Response Team.

Objective 6: Develop coordination and a learning community between each Regional Response Teams

1. Each regional response dedicates a BH Navigator and BH Coordinator/Manager to the response
2. The BH Surge Contractor documents and spreads processes and model from Kids' Mental Health Pierce County to other regions.
3. BH Surge Contractor convenes a learning community across the regions.
4. BH Surge Management contractor supports development of metrics and reporting process to track progress and implementation.

Integrated Managed Care Child/Adolescent Behavioral Health Performance Measures and Financial Data

Behavioral Health Integration Subgroup

May 3, 2021



Two sources of data

- ▶ Financial Data source: Milliman (HCA actuary)
 - ▶ Managed Care encounter data used for rate setting

- ▶ Behavioral Health measures source: Research and Data Analysis, DSHS
 - ▶ Managed Care Enrollees only

Integrated Managed Care Actuarial Data For 2021



BEHAVIORAL HEALTH TREATMENT NEED FOR ALL APPLE HEALTH CHILDREN BY AGE GROUP – SFY 2018

| AGE GROUP | ALL MEDICAID CHILDREN | BH TREATMENT NEED |
|--------------------|-----------------------|-------------------|
| Ages 0 – 4 | 296,470 | 5% |
| Ages 5 – 11 | 353,638 | 20% |
| Ages 12 – 17 | 255,497 | 33% |
| Ages 0 – 17 | 905,605 | 19% |
| Ages 18 – 20 | 98,873 | 37% |

BEHAVIORAL HEALTH SERVICE NEED AND PENETRATION

| Summary of BH Treatment Needs | CY 2018 | CY 2019 |
|--|---------|---------|
| Children (Age 0-18) in Managed Care (MC) | 802,115 | 789,429 |
| % of Medicaid Children (0-17) with a BH need in SFY 2018 | 19% | 19% |
| Estimated Children in MC with BH treatment need | 150,453 | 148,074 |
| Summary of High Acuity BH Treatment Penetration: “high acuity BH” in this context was intended to represent the set of BH services previously covered by the BHOs | | |
| MC Children Using 3+ BH Services | 36,697 | 37,925 |
| Percent of MC Children Using 3+ BH Services: This is a percentage of the total IMC-enrolled child population | 5% | 5% |
| Treatment Penetration for Children in MC: This is a percentage of the subset of IMC child population who have BH needs | 24% | 26% |

SUMMARY – COMPARATIVE BEHAVIORAL HEALTH METRICS – 2019

| SUMMARY | CHILD | ADULT | TOTAL POP |
|---|---------------|---------------|------------------|
| Average Monthly Enrollment | 796,236 | 865,147 | 1,661,383 |
| Average Monthly Managed Care Benefit Cost | \$130 Million | \$339 Million | \$469.75 Million |
| BH-Related ED Utils/1000 | 8.8 | 59.7 | 33.2 |
| BH-Related ED Paid as % of Total Benefit Cost | 0.05% | 0.33% | 0.37% |
| IP Psych Utils/1000 | 29.1 | 212.5 | 124.6 |
| IP Psych Paid as a % of Total Benefit Cost | 1.8% | 3.7% | 3.2% |
| Non-specialty BH PMPM | \$5.38 | \$4.80 | \$5.08 |
| Total Behavioral Health Benefit PMPM | \$31.03 | \$73.34 | \$53.06 |
| % Behavioral Health of Total Benefit Cost | 18.9% | 18.7% | 18.8% |

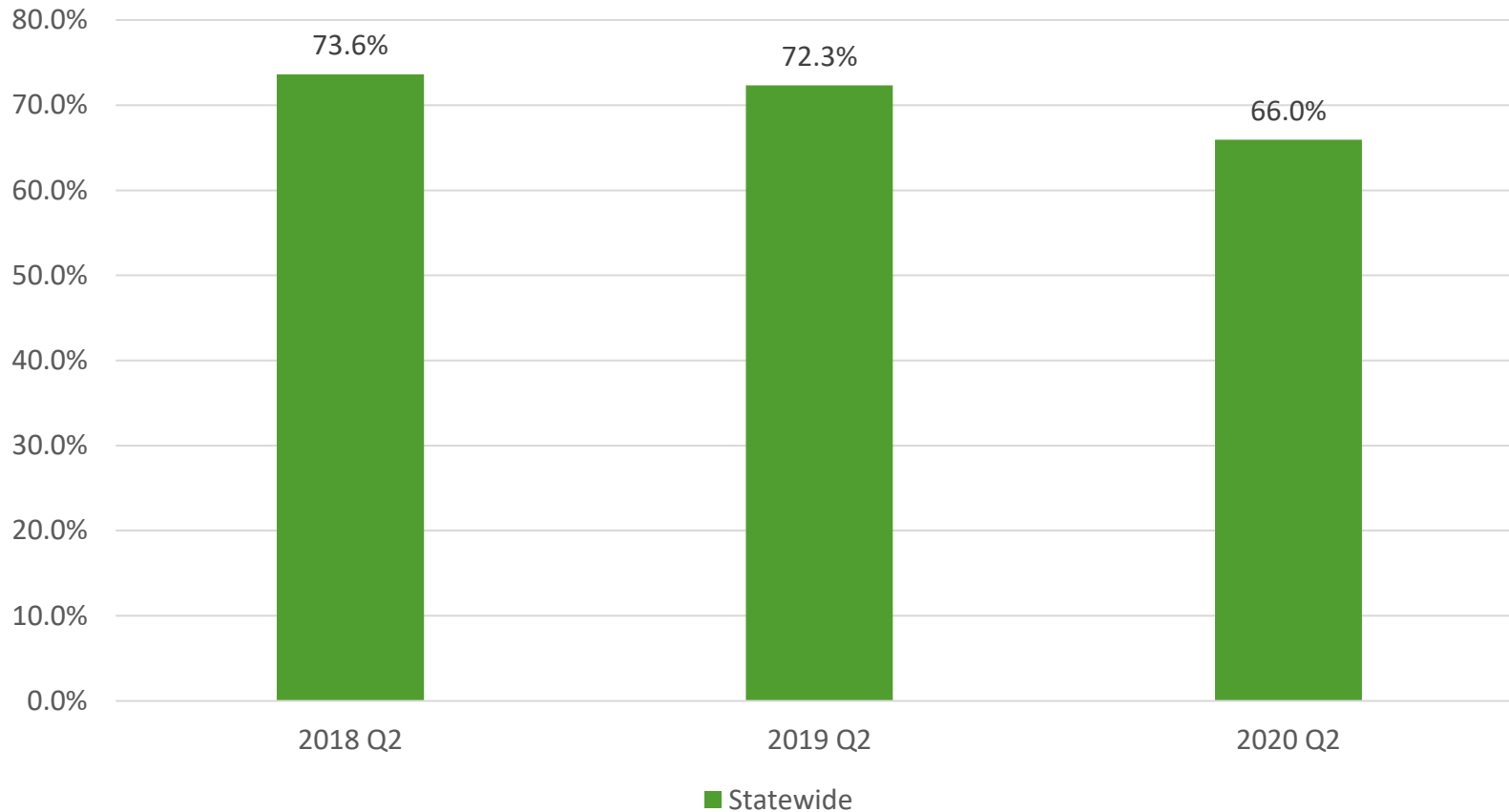
STATEWIDE COST MODELS FOR CHILDREN (AGE 18 AND UNDER) AND ADULTS, CY 2019

| SERVICE MODALITY | CHILD/ADOLESCENT | | | ADULT (18+) | | |
|----------------------|------------------|-----------|--------|-------------|-----------|---------|
| | UTILIZATION | UTIL/1000 | PMPM | UTILIZATION | UTIL/1000 | PMPM |
| MH INPATIENT | | | | | | |
| INPATIENT HOSP – MH | 23,133 | 29.1 | \$3.00 | 183,807 | 212.5 | \$14.45 |
| RESIDENTIAL MH | 4,650 | 5.8 | \$0.22 | 160,188 | 185.2 | \$3.34 |
| CRISIS STABILIZATION | 2,104 | 2.6 | \$0.06 | 55,861 | 64.6 | \$1.88 |
| SUD INPATIENT | | | | | | |
| INPATIENT HOSP – SUD | 164 | 0.2 | \$0.02 | 2,403 | 2.8 | \$0.21 |
| RESIDENTIAL SUD | 25,293 | 31.8 | \$0.67 | 328,068 | 379.2 | \$6.52 |

Selected Behavioral Health Performance Measures Through June 2020

Regional Performance

Children/Adolescent (6-17) With Mental Health Needs: Follow-up After ED Visit For Mental Illness – Within 7 Days

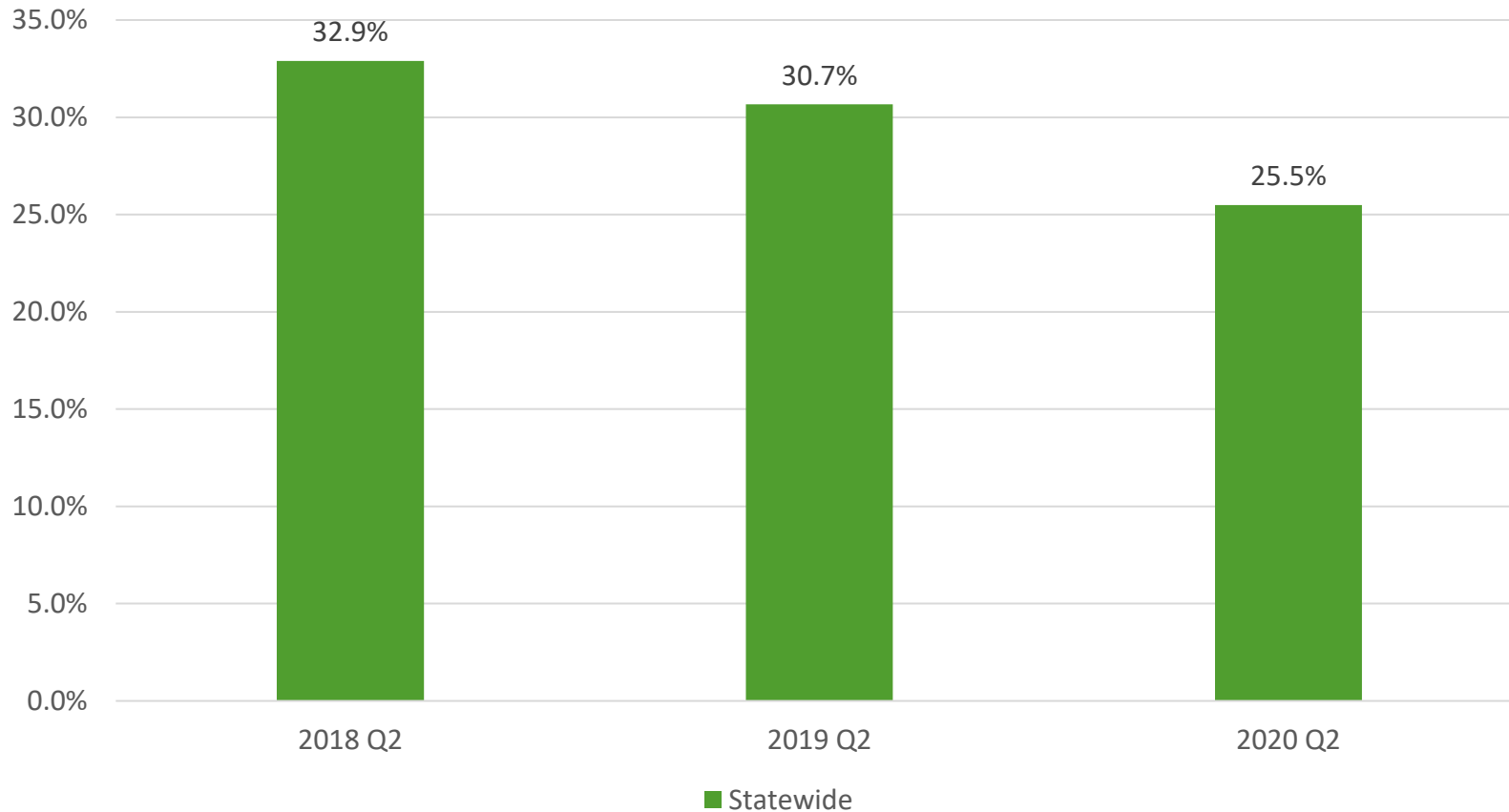


*Statewide 2020 Q2
Range: 55.3% - 82.1%*

Children/Adolescent (6-17) With Mental Health Needs: Follow-up After ED Visit For Mental Illness – Within 7 Days – by Accountable Community Health Region

| REGION | YR ENDING Q2 2018 | YR ENDING Q2 2019 | YR ENDING Q2 2020 |
|--------------------------------------|-------------------|-------------------|-------------------|
| Better Health Together (Spokane) | 73.7% | 73.7% | 73.6% |
| Cascade Pacific Action Alliance | 74.7% | 73.1% | 67.5% |
| Elevate Health (Pierce) | 77.2% | 81.3% | 66.2% |
| Greater Columbia ACH | 86.1% | 75.7% | 62.8% |
| Healthier Here (King) | 70.3% | 63.0% | 55.3% |
| North Central ACH | 83.7% | 82.5% | 82.1% |
| North Sound ACH | 69.2% | 68.5% | 58.7% |
| Olympic Community of Health (Salish) | 70.2% | 74.0% | 69.2% |
| SouthWest ACH | 62.1% | 71.1% | 70.2% |

Children/Adolescent (10-17) With SUD Treatment Needs: Substance Use Disorder Treatment Penetration



*Statewide 2020 Q2
Range: 17.6% - 36.8%*

Children/Adolescent (10-17) With SUD Treatment Needs: Substance Use Disorder Treatment Penetration – by Accountable Community of Health Region

| REGION | YR ENDING Q2 2018 | YR ENDING Q2 2019 | YR ENDING Q2 2020 |
|--------------------------------------|-------------------|-------------------|-------------------|
| Better Health Together (Spokane) | 26.2% | 28.9% | 24.5% |
| Cascade Pacific Action Alliance | 46.1% | 42.6% | 36.6% |
| Elevate Health (Pierce) | 25.8% | 25.9% | 24.0% |
| Greater Columbia ACH | 37.3% | 32.5% | 24.4% |
| Healthier Here (King) | 29.6% | 24.4% | 20.0% |
| North Central ACH | 29.9% | 24.7% | 17.6% |
| North Sound ACH | 32.5% | 26.7% | 24.3% |
| Olympic Community of Health (Salish) | 26.7% | 38.9% | 29.9% |
| SouthWest ACH | 39.2% | 38.8% | 36.8% |

STATEWIDE COST MODELS FOR CHILDREN (AGE 18 AND UNDER) AND ADULTS, CY 2019

| SERVICE MODALITY | CHILD/ADOLESCENT | | | ADULT (18+) | | |
|-----------------------------|------------------|-----------|---------|-------------|-----------|-------|
| | UTILIZATION | UTIL/1000 | PMPM | UTILIZATION | UTIL/1000 | PMPM |
| OUTPATIENT MH | 901,607 | 1132.3 | \$10.17 | 2,489,125 | 2,877.1 | 25.68 |
| OUTPATIENT SUD | 69,801 | 87.7 | \$0.42 | 3,796,142 | 4,387.9 | 9.46 |
| NON-SPECIALTY BH | | | | | | |
| INPATIENT HOSP BH | 995 | 1.2 | \$0.08 | 14,591 | 16.9 | 1.29 |
| ANCILLARY BH | 212,999 | 267.5 | \$0.98 | 413,536 | 478.0 | 1.72 |
| APPLIED BEHAVIOR ANALYSIS | 207,779 | 261.0 | \$4.06 | 1,501 | 1.7 | 0.02 |
| ER CLAIMS w/BH DIAGNOSIS | 6,974 | 8.8 | \$0.27 | 43,402 | 50.2 | 1.78 |
| OTHER SUBCAPITATED SERVICES | | | \$1.87 | | | 6.98 |
| WISe SERVICES | | | \$9.23 | | | |

CY 2019 EMERGENCY DEPARTMENT UTILIZATION

| | ER ENCOUNTERS – MEMBERS WITH BH DIAGNOSES | ALL ER ENCOUNTERS | % BH-RELATED ER |
|------------------------|--|----------------------|-----------------|
| AGE/GENDER GROUP | UTILIZATION/1000 | UTIL/1000 | UTIL/1000 |
| AGE 3-14 CHILDREN | 5.9 | 322.0 | 1.8% |
| AGE 15-18 FEMALE | 29.6 | 502.5 | 5.9% |
| AGE 15-18 MALE | 25.0 | 325.8 | 7.7% |
| AGE 19-34 FEMALE | 45.4 | 873.0 | 5.2% |
| AGE 19-34 MALE | 85.2 | 686.5 | 12.4% |
| AGE 35-64 FEMALE | 42.8 | 780.0 | 5.5% |
| AGE 35-64 MALE | 75.9 | 784.8 | 9.7% |
| AGE 65+ | 11.4 | 461.0 | 2.4% |
| CHILD/ADOLESCENTS 0-18 | 8.8 | 410.7 | 2.2% |
| ADULTS 19+ | 59.7 | 788.5 | 7.6% |
| TOTAL | 33.2 | 591.8 | 5.6% |

Washington Medicaid Children's Behavioral Health Summary - DRAFT

Jennifer L Gerstorff, FSA, MAAA
 Daniel T Gerber, ASA, MAAA
 Joseph E Whitley, MPP



Milliman, Inc. (Milliman) has been retained by the Washington State Health Care Authority (HCA) to provide actuarial and consulting services related to the development of actuarially sound capitation rates for its Apple Health Managed Care programs. As part of these analyses, HCA has requested that we provide summary exhibits of readily available information about the utilization of Medicaid behavioral health services for children enrolled in managed care.

This memorandum presents the requested information based on our prior actuarial analyses, as well as a high-level overview of the program from an actuarial perspective to assist with interpretation of certain technical aspects within the attached exhibits.

This document is intended to facilitate discussion on children's Medicaid behavioral health services between HCA and members of the Children and Youth Behavioral Health Work Group (CYBHWG) and may not be appropriate for any other purposes. This memorandum and its attachments should not be distributed beyond intended users without prior written consent of the authors.

Summary Results

Figure 1 illustrates comparative metrics for children and adults based on CY 2019 managed care experience, including BH-related emergency department (ED) and inpatient psych treatment expenditures, and per member per month (PMPM) cost for low-level BH treatment and higher acuity behavioral health benefit package services. Additional details explaining definitions, methodology, and more detailed metrics can be found in the attachments to this memorandum.

EXHIBIT 1: EXECUTIVE SUMMARY – COMPARATIVE BEHAVIORAL HEALTH METRICS

| Executive Summary | Child | Adult | Total |
|---|------------|------------|------------|
| Member Months | 9,554,828 | 10,381,769 | 19,936,597 |
| Total Managed Care Benefit Cost (\$mil) | \$ 1,565.0 | \$ 4,071.9 | \$ 5,637.0 |
| BH-Related ED Utilis/1000 | 8.8 | 59.7 | 33.2 |
| BH-Related ED Paid as % of Total Benefit Cost | 0.05% | 0.33% | 0.37% |
| IP Psych Utilis/1000 | 29.1 | 212.5 | 124.6 |
| IP Pysch Paid as a % of Total Benefit Cost | 1.8% | 3.7% | 3.2% |
| Low Level BH PMPM | \$ 5.38 | \$ 4.80 | \$ 5.08 |
| Total Behavioral Health Benefit PMPM | \$ 31.03 | \$ 73.34 | \$ 53.06 |
| % Behavioral Health of Total Benefit Cost | 18.9% | 18.7% | 18.8% |

Attachments Overview

We have prepared four attachments intended to provide additional context for discussion on children's behavioral health experience in the Washington Medicaid program. The exhibits presented in these attachments were not prepared to directly respond to the CYBHWG subgroup's questions, but rather were compiled from previous analyses developed for HCA in support of Apple Health Managed Care programs. We have summarized each attachment below.

1. BRIEF OVERVIEW MEMO

Using information from our CY 2021 capitation rate certification reports:

- Brief overview memo defining key terms, overview of behavioral health in the managed care program, and including links to additional resources

- This background information is essential for understanding the complexities and nuances of the data provided in the remaining attachments of this document

2. BEHAVIORAL HEALTH EXPERIENCE SUMMARIES

Using available information from the databooks created with our CY 2021 capitation rate development:

- Cost models (including member months, utilization per 1,000, unit cost, and PMPM cost) by high-level service category for children and adults
- Estimated managed care expenditures for children's behavioral health services in 2019 and 2021
- The experience summaries include child and adult utilization rates and expenditures for inpatient psych hospitalization

3. EMERGENCY DEPARTMENT UTILIZATION

Using available information from the emergency department (ED) efficiency adjustment analysis conducted during 2021 capitation rate development:

- Child and adult utilization rates for BH-related ED visits and total ED visits, stratified by detailed age groups
- Child and adult expenditures for BH-related ED visits and total ED visits, stratified by detailed age groups

4. BEHAVIORAL HEALTH TREATMENT NEEDS AND PENETRATION

Using publicly available research from DSHS¹:

- Comparison of children's behavioral health treatment needs and treatment penetration
- This includes the number of children with at least three behavioral health services during a calendar year period

Attachment 1: Program Overview

HCA administers the Apple Health Medicaid program through a combination of fee-for-service (FFS) and managed care delivery systems. A majority of the services are paid through managed care contracts as the majority of the Medicaid population is enrolled in managed care. The state covers some benefits on a FFS basis for all qualifying Medicaid enrollees, such as long-term support services administered by AL TSA and DDA.

Managed care contracts are statewide, although not all managed care organizations (MCOs) serve each region. The following outlines a few key historical program changes:

- i Risk-based managed care for physical health benefits has been mandatory in Washington since 1987.
- i From April 2016 to January 2020, as part of a phased in approach by region, HCA shifted the behavioral health benefit package into the responsibility of MCOs and migrated away from behavioral health organizations (BHOs). The following outlines the timeline for the regional rollout of the integration of physical and behavioral healthcare into managed care.
 - Early adopter region (April 2016): Southwest Washington
 - Mid-adopter region phase 1 (January 2018): North Central
 - Mid-adopter regions phase 2 (January 2019): King County, Greater Columbia, Pierce, Spokane
 - Late adopter regions (January 2020): Salish, Great Rivers, Thurston-Mason

A service map illustrating the counties within each region can be found on HCA's website.²

BEHAVIORAL HEALTH IN MANAGED CARE

In Washington's currently integrated managed care programs, HCA makes capitation payments to the MCOs on a per-member per-month (PMPM) basis to cover the cost of services and administration of the benefit for each person enrolled with an MCO.

For members enrolled in managed care, there are two main components to the monthly capitation rates: (1) the physical health benefit package and (2) the behavioral health benefit package. Most children have both physical and behavioral health covered under managed care, although there are a small number who receive only the behavioral health benefit. Some children opt out of managed care and have their benefits administered by HCA through the FFS program.

The state's actuaries develop PMPM payments separately for the behavioral health benefit package and the physical health benefit package. Between April 2016 and January 2020, as Washington Medicaid integrated physical and behavioral health managed care in different regions, both Milliman and Mercer were involved in developing these behavioral health managed care payment rates. As a result, the data available to Milliman to perform the analyses in this memo is limited for regions that integrated later in that time period. We have noted in the attachments when exhibits are limited to the early/mid-adopter regions or include statewide information.

There are additional services covered under separate contracts with the MCOs, which do not fall under the monthly capitation rate benefits. These include case rate payments and payments for non-Medicaid behavioral health services.

Provider Payments from MCOs

One important component to understand is the lack of detailed information for every service provided through managed care. This is particularly prominent as the delivery system for behavioral health services is integrated with the legacy physical health managed care program, because the primary type of payment arrangements for behavioral health services are non-standard provider reimbursement arrangements with insufficiently reported encounters to support an understanding of service utilization. Thus, a significant portion of BH expenditures paid to providers do not rely on direct fee-for-service payment of claims. MCOs generally report these payments to us as a lump sum for an entire region, and the proportion of these that are attributable to children is an estimate that may not be representative of actual treatment cost for a subgroup of the population. The proportion of spend associated with these types of payments varies drastically by region but can range from 10% - 40% of the total behavioral health benefit package. In contrast, nearly all physical health benefit package services are supported by encounters from a claims system.

In CY 2019, many providers in newly integrated regions received payment for services through one of the following methods, where the MCO makes payments to the provider outside the standard claim payment system while also collecting encounters that are submitted to P1 with or without provider payment details:

- i **INVOICE BILLING:** providers submit invoices to MCOs for eligible services for an MCO's enrollees. Encounters are submitted to the MCOs, but tend to be incomplete or have longer lags than traditional encounter data.

- **PERCENT OF PREMIUM CAPITATED ARRANGEMENTS:** MCOs pay a portion of the overall BH capitation to providers based on a provider's historical share of BHO funding. In early periods following transition, encounters tend to be significantly incomplete.
- **BUDGET-BASED CAPITATED ARRANGEMENTS:** providers submit invoices to MCOs at the client level rather than the service level, and payments are based on a provider's historical share of BHO funding, attributed to each MCO based on the distribution of members treated by MCO.
- **BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ONLY (BH-ASO) ARRANGEMENTS:** third party organizations are used to administer crisis-related services as part of the state's integrated managed care model. BH-ASOs provide assessment, intervention, and stabilization services. They are paid on a monthly subcapitated basis with subsequent settlements based on submitted encounters in an effort to stabilize cash flow to providers.

MANAGED CARE PROGRAM TERMS AND DEFINITIONS

This section outlines key terms and definitions that are commonly used in actuarial work produced for HCA. This is intended to be a quick reference guide to better understanding our exhibits.

Behavioral health benefit package

As noted above, HCA's managed care program covers both physical and behavioral health benefits for most Medicaid enrollees. We use the term "behavioral health benefit package" to distinguish treatment for moderate- to high-acuity behavioral health needs. The behavioral health benefit package is categorized separately from other Medicaid benefits covered under managed care. This subset of managed care covered benefits was previously administered by Behavioral Health Organizations (BHOs), and is now provided by MCOs under an integrated contract. The behavioral health benefit is defined through the following references:

- ┆ Services defined in Section 13.d (mental health rehabilitation option) of the state's Medicaid State Plan.³
- ┆ Service descriptions are provided in the state's Service Encounter Reporting Instructions.⁴
- ┆ Limited to Medicaid-covered services in the MCOs' main Integrated Managed Care contract⁵

Low-level behavioral health services

We use the term "low-level behavioral health" to represent treatment for low-acuity behavioral health needs, covered under the physical health benefit package of managed care. These services have been covered by MCOs historically and include the following types of benefits:

- ┆ services rendered by non-BHA providers such as outpatient treatment in a PCP office setting, treatment in the emergency department of acute care hospitals, and inpatient treatment for co-occurring acute and behavioral health diagnoses.
- ┆ Applied behavioral analysis (ABA) treatment is also included in the physical health benefit package

Wraparound with Intensive Services (WISe)

WISe is a Medicaid-funded range of service components that are individualized, intensive, coordinated, comprehensive, culturally competent, home and community based for children and youth who have a mental disorder that is causing severe disruptions in behavior. Treatment requires coordination of services and support, intensive care collaboration and ongoing intervention to stabilize the child and family to prevent more restrictive or institutional placement. WISe team members provide a high level of flexibility in accommodating families by working evenings and weekends and responding to crises 24 hours a day, seven days a week.

Additional information on WISe can be found in a fact sheet published on HCA's website.⁶

Behavioral Health Agency (BHA)

Providers who are licensed by the state to provide moderate- to high-acuity behavioral health services under the behavioral health benefit package. The state publishes the list of BHAs in an online directory for reference.⁷ For services that may be used to treat a range of acuity needs, we rely on the rendering provider type (BHA vs non-BHA) reported in claims to distinguish between low-level behavioral health treatment and services covered by the behavioral health benefit package.

Case rate payment

Payments made to MCOs whenever certain case criteria is met. For example, in addition to monthly capitation payments, HCA makes a payment to MCOs for WISe services whenever a child has received at least one WISe-qualifying service in a month.

Monthly Capitation Payments

Capitation payments are projected benefit costs that are paid to MCOs on a PMPM basis for each person enrolled with an MCO. The capitation payment is intended to cover the cost of services and administration of the benefit packages.

Aid categories

Population groups are defined by recipient aid category (RAC) codes, which are used to group cohorts of Medicaid enrollees together based on their eligibility pathway (e.g., low-income families, children enrolled through DCYF, children with intellectual or developmental disabilities enrolled through DDA)

Monthly capitation payments vary by aid categories to reflect differences in service utilization for children with different levels of need.

ACTUARIAL COST MODEL METRIC DEFINITIONS

We have provided actuarial cost models in Attachment 2. These models show historical reported experience and projections for a specific population, split out by service category. They include the following metrics:

- i **MEMBER MONTHS:** Count of enrolled members in each month of a time period.
- i **PER MEMBER PER MONTH COST (PMPM):** Average monthly cost of services per enrolled member.
 - Used as a metric to evaluate expenditures on a basis that is normalized for differences in population size.
 - Calculated as expenditures divided by member months.
- i **UTILIZATION PER 1,000 MEMBER MONTHS:** Average number of units of service provided per 1,000 member months.
 - Used as a metric to evaluate utilization of services on a basis that is normalized for differences in population size.
 - Calculated as units divided by member months multiplied by 12,000
- i **UNIT COST:** Cost of services on a per-unit basis.
 - Calculated as expenditures divided by units.

Attachment 2: Experience Summaries

Exhibits in this attachment include experience for members and services covered under managed care arrangements with either MCOs or BHOs, including the following programs:

- Apple Health Integrated Managed Care (IMC)
- Behavioral Health Services Only (BHSO)
- Integrated Foster Care (IFC)
- Wraparound with Intensive Services (WISe)

Exhibits include the following managed care experience summaries:

- CY 2019 historical statewide cost models for children (age 18 and under) and adults
 - Includes IMC, BHSO, IFC, and WISe
- CY 2021 projected experience limited to regions that were integrated as of January 1, 2019 (early/mid-adopters)
 - Includes IMC and BHSO
 - Excludes IFC and WISe

The CY 2019 cost models and CY 2021 experience projections are stratified into broad service categories, including inpatient and outpatient treatment provided under the behavioral health benefit package, and low-level behavioral health services covered under the physical health benefit package. Definitions of these benefit packages can be found in Attachment 1.

EXHIBIT 2.1: CY 2019 HISTORICAL STATEWIDE COST MODELS FOR CHILDREN (AGE 18 AND UNDER) AND ADULTS

| | CY 2019 MMs: 9,554,828 | | | | | CY 2019 MMs: 10,381,769 | | | | |
|--|------------------------|-------------------|-----------|-----------------|------------------|-------------------------|-------------------|-----------|-----------------|------------------|
| | Children (Ages 0-18) | | | | | Adults (Age 19+) | | | | |
| Service Modality | Paid (\$mil) | Utilization | Unit Cost | Utils/1000 | PMPM | Paid (\$mil) | Utilization | Unit Cost | Utils/1000 | PMPM |
| MH Inpatient | | | | | | | | | | |
| Inpatient Hospital - MH | \$ 28.7 | 23,133 | 1,239.57 | 29.1 | \$ 3.00 | \$ 150.0 | 183,807 | 815.98 | 212.5 | \$ 14.45 |
| Residential MH | 2.1 | 4,650 | 443.55 | 5.8 | 0.22 | 34.7 | 160,188 | 216.77 | 185.2 | 3.34 |
| Crisis Stabilization | 0.6 | 2,104 | 293.07 | 2.6 | 0.06 | 19.6 | 55,861 | 350.19 | 64.6 | 1.88 |
| SUD Inpatient | | | | | | | | | | |
| Inpatient Hospital - SUD | 0.2 | 164 | 1,219.04 | 0.2 | 0.02 | 2.2 | 2,403 | 896.05 | 2.8 | 0.21 |
| Residential SUD | 6.4 | 25,293 | 252.11 | 31.8 | 0.67 | 67.7 | 328,068 | 206.35 | 379.2 | 6.52 |
| Outpatient MH | 97.2 | 901,607 | 107.77 | 1,132.3 | 10.17 | 266.6 | 2,489,125 | 107.12 | 2,877.1 | 25.68 |
| Outpatient SUD | 4.1 | 69,801 | 58.13 | 87.7 | 0.42 | 98.2 | 3,796,142 | 25.88 | 4,387.9 | 9.46 |
| Low Level BH¹ | | | | | | | | | | |
| Inpatient Hospital BH | 0.7 | 995 | 749.19 | 1.2 | 0.08 | 13.4 | 14,591 | 920.71 | 16.9 | 1.29 |
| Ancillary BH | 9.3 | 212,999 | 43.79 | 267.5 | 0.98 | 17.8 | 413,536 | 43.07 | 478.0 | 1.72 |
| Applied Behavior Analysis | 38.8 | 207,779 | 186.50 | 261.0 | 4.06 | 0.2 | 1,501 | 126.93 | 1.7 | 0.02 |
| ER Claims with BH Diagnosis | 2.5 | 6,974 | | 8.8 | 0.27 | 18.4 | 43,402 | | 50.2 | 1.78 |
| Other Subcapitated Services | 17.8 | | | | 1.87 | 72.5 | | | | 6.98 |
| WISe Services³ | 88.2 | | | | 9.23 | 0.0 | | | | - |
| Total Behavioral Health⁴ | \$ 296.5 | 1,455,500 | | 1,828.0 | \$ 31.03 | \$ 761.4 | 7,488,624 | | 8,655.9 | \$ 73.34 |
| Total Managed Care Benefit Cost⁵ | \$ 1,565.0 | 12,683,313 | | 15,929.1 | \$ 163.80 | \$ 4,071.9 | 35,737,403 | | 41,307.9 | \$ 392.22 |
| %BH | 19% | 11% | | | | 19% | 21% | | | |

1 This exhibit excludes low-level BH for the COPES population since rates for this population are not split by ageband.

2 Starting in February 2021, adults over age 21 are eligible for ABA services. The projections in this exhibit do not reflect this program change.

3 WISe Services are provided to members age 0-20. We have included all of these services in the "children" category.

4 Total Behavioral Health costs include benefits covered under IFC and WISe case payments as well as low-level behavioral health costs under the physical health capitation rate.

5 Total Benefit Costs include benefits covered under IFC, IMC, and BHSO monthly capitation, delivery case rate, WISe case rate, and Rx payments.

6 A significant portion of behavioral health services are paid outside of the claims system. Age-gender allocation of these services is estimated

EXHIBIT 2.2: CY 2021 PROJECTED EXPERIENCE LIMITED TO REGIONS THAT WERE INTEGRATED AS OF JANUARY 1, 2019 (EARLY/MID-ADOPTERS)

| | Projected CY21 MMs: | | 7,999,286 | |
|--|----------------------|------------------|-------------------|------------------|
| Service Modality | Children (Ages 0-18) | | Adults (Age 19+) | |
| | Paid (\$mil) | PMPM | Paid (\$mil) | PMPM |
| MH Inpatient | | | | |
| Inpatient Hospital - MH | \$ 23.0 | \$ 3.32 | \$ 139.8 | \$ 17.47 |
| Residential MH | 1.9 | 0.27 | 34.3 | 4.28 |
| Crisis Stabiliation | 0.2 | 0.03 | 14.0 | 1.75 |
| SUD Inpatient | | | | |
| Inpatient Hospital - SUD | 0.2 | 0.03 | 2.6 | 0.32 |
| Residential SUD | 3.9 | 0.56 | 49.8 | 6.23 |
| Outpatient MH | 70.0 | 10.13 | 246.3 | 30.79 |
| Outpatient SUD | 2.6 | 0.37 | 84.8 | 10.61 |
| Low Level BH¹ | | | | |
| Inpatient Hospital BH | 0.4 | 0.06 | 11.8 | 1.48 |
| Ancillary BH | 7.3 | 1.05 | 17.0 | 2.13 |
| Applied Behavior Analysis | 24.8 | 3.59 | 0.2 | 0.02 |
| Other Subcapitated Services | 16.2 | 2.35 | 76.5 | 9.57 |
| Total Behavioral Health³ | \$ 150.4 | \$ 21.76 | \$ 677.1 | \$ 84.64 |
| Total Managed Care Benefit Cost⁴ | \$ 1,089.4 | \$ 157.63 | \$ 3,376.0 | \$ 422.03 |
| % BH | 14% | 14% | 20% | 20% |

1 This exhibit excludes low-level BH for the COPES population since rates for this population are not split by ageband.

2 Starting in February 2021, adults over age 21 are eligible for ABA services. The projections in this exhibit do not reflect this program change.

3 Total Behavioral Health costs exclude benefits covered under IFC and WISE case payments as well as ER claims for members with a BH diagnosis, but include low-level behavioral health costs covered under the physical health capitation rate.

4 Total Benefit Costs include benefits covered under IMC and BHSO monthly capitation, delivery case rate, and Rx payments, but exclude WISE and IFC case payments.

5 A significant portion of behavioral health services are paid outside of the claims system. Age-gender allocation of these services is estimated.

DATA SOURCES

Exhibits within this attachment rely on data from several sources:

- Encounter data reported by MCOs for service dates CY 2019 and submitted to the state's ProviderOne (P1) data warehouse through June 2020, as documented in our CY 2021 capitation rate report⁹.
- MCO-reported payments made to providers outside of the claims system.
- Late Adopter Region Capitation Rate Certification, submitted to HCA by Mercer and dated December 3, 2020.⁸ This includes fee-for-service claims and BHO encounters reported to P1. Base experience is reported on a CY 2019 basis, blending adjusted CY 2018 and CY 2019 experience as documented in Appendix D of the certification.

CAVEATS AND CONSIDERATIONS

- There are significant differences in reporting and benefit cost development between the early/mid-adopter regions and the late adopter regions. These differences are described in full in our IMC rate certification, originally delivered to HCA on December 21, 2020.⁹
- Benefit costs do not include expenditures associated with MCO administration, risk margin, or taxes.
- Projected CY 2021 benefit cost development is described in detail in our IMC rate certification, and includes adjustments for medical trend and targeted program changes.

- i Starting in February 2021, adults age 21 and over are eligible for ABA services. CY 2021 projections do not reflect this program change.
- i Cost models exclude low-level BH for the COPES population, as capitation rate data for this population is not readily available at the age-group level.
- i Members are eligible for WISE services through age 20. We have included all WISE expenses in the “child” category as the data is not readily available to present at a more detailed age group level.
- i Adjustments to the data are primarily documented in our CY 2021 capitation rate certification report.⁹ Additional adjustments have been made to improve consistency and convert utilization into days for daily services and hours for hourly services.

Attachment 3: Emergency Department Utilization

This attachment relies on an algorithm developed by New York University to categorize emergency room encounters into broad service categories based on their primary diagnosis code.¹⁰ We used this categorization method to identify behavioral health-related emergency room encounters in CY 2019 experience submitted to ProviderOne by MCOs. These encounters are covered under the physical health managed care benefit, but have a primary diagnosis related to behavioral health.

EXHIBIT 3: EMERGENCY DEPARTMENT UTILIZATION

| Age/Gender Cell | ER Encounters for Members with a BH Diagnosis | | | | | All ER Encounters | | % BH-related ER | |
|---------------------------------------|---|-------------------|-------------------|-------------|----------------|-------------------|-----------------|-----------------|-------------|
| | MMs | Paid | Utilization | Utils/1000 | PMPM | Utils/1000 | PMPM | Utils/1000 | PMPM |
| Children under age 1 | 531,465 | \$ 0.0 | 24 | 0.5 | \$ 0.01 | 897.8 | \$ 19.91 | 0.1% | 0.1% |
| Age 1-2 children | 1,013,220 | 0.0 | 21 | 0.2 | 0.01 | 695.1 | 15.92 | 0.0% | 0.0% |
| Age 3-14 children | 6,215,875 | 1.0 | 3,038 | 5.9 | 0.15 | 322.0 | 8.79 | 1.8% | 1.8% |
| Age 15-18 female | 849,695 | 0.9 | 2,097 | 29.6 | 1.01 | 502.5 | 17.34 | 5.9% | 5.8% |
| Age 15-18 male | 862,806 | 0.7 | 1,795 | 25.0 | 0.82 | 325.8 | 11.26 | 7.7% | 7.3% |
| Age 19-34 female | 2,453,309 | 3.7 | 9,286 | 45.4 | 1.51 | 873.0 | 29.21 | 5.2% | 5.2% |
| Age 19-34 male | 1,688,061 | 4.5 | 11,984 | 85.2 | 2.65 | 686.5 | 21.62 | 12.4% | 12.2% |
| Age 35-64 female | 2,441,406 | 4.2 | 8,715 | 42.8 | 1.71 | 780.0 | 31.01 | 5.5% | 5.5% |
| Age 35-64 male | 2,119,664 | 6.1 | 13,399 | 75.9 | 2.87 | 784.8 | 29.98 | 9.7% | 9.6% |
| Age 65+ | 20,131 | 0.0 | 19 | 11.4 | 0.37 | 481.0 | 22.75 | 2.4% | 1.6% |
| Children age 0-18 | 9,473,061 | \$ 2.5 | 6,974 | 8.8 | \$ 0.27 | 410.7 | \$ 11.17 | 2.2% | 2.4% |
| Adults age 19+ | 8,722,571 | \$ 18.4 | 43,402 | 59.7 | \$ 2.11 | 788.5 | \$ 28.42 | 7.6% | 7.4% |
| Total | 18,195,632 | \$ 21.0 | 50,376 | 33.2 | \$ 1.15 | 591.8 | \$ 19.44 | 5.6% | 5.9% |
| Total Benefit Cost² | | \$ 5,637.0 | 48,420,716 | | | | | | |
| % ER | | 0.4% | 0.1% | | | | | | |

1 This exhibit is limited to members with physical health managed care coverage (excludes BHSO)

2 Total Benefit Costs include benefits covered under IFC, IMC, and BHSO monthly capitation, delivery case rate, WISE case rate, and Rx payments.

PROGRAMS AND SERVICES

This exhibit is limited to members with physical health managed care coverage (IMC and IFC). Emergency services for BHSO members are covered outside of managed care. Cost model metrics are reported for each age and gender category, for behavioral health-related ER visits and for total ER visits. The costs reported in this exhibit include the institutional and professional components of the ER visits.

CAVEATS AND CONSIDERATION

Emergency department encounters typically include several diagnosis codes. This analysis uses only the primary diagnosis code, so encounters with a non-BH primary diagnosis but BH-related secondary diagnoses are not identified as BH-related.

Attachment 4: Behavioral Health Treatment Needs and Penetration

This attachment uses publicly available research from the Washington State Department of Social and Health Services (DSHS) to compare behavioral health treatment needs for children to demonstrated behavioral health treatment in Medicaid encounter data.

Figure 4.1 provides summary information from exhibit A. Population Reference Table from the DSHS report, including number of children enrolled in Medicaid and the percentage of those children with a behavioral health treatment need in SFY 2018 as identified by RDA. Note that the DSHS report provides several exhibits illustrating behavioral health treatment prevalence and related outcomes in different settings (see Section 2. Outcome Measures).¹

EXHIBIT 4.1: BEHAVIORAL HEALTH TREATMENT NEED FOR ALL APPLE HEALTH CHILDREN BY AGE GROUP – SFY 2018

| AGE GROUP | ALL MEDICAID CHILDREN | BH TREATMENT NEED |
|--------------------|-----------------------|-------------------|
| Ages 0 – 4 | 296,470 | 5% |
| Ages 5 – 11 | 353,638 | 20% |
| Ages 12 – 17 | 255,497 | 33% |
| Ages 0 – 17 | 905,605 | 19% |
| Ages 18 – 20 | 98,873 | 37% |

Figure 4.2 summarizes the number of children enrolled in Medicaid managed care for physical health services during CY 2018 and CY 2019, with an extrapolated estimate of children in managed care with a BH treatment need (based on information from Figure 4.1), and provides the number of children who received at least three behavioral health benefit package services through an MCO or BHO within the year.

EXHIBIT 4.2: BEHAVIORAL HEALTH SERVICE NEED AND PENETRATION

| Summary of BH Treatment Needs | CY 2018 | CY 2019 |
|--|---------|---------|
| Children (Age 0-18) in Managed Care (MC) | 802,115 | 789,429 |
| % of Medicaid Children (0-17) with a BH need in SFY 2018 | 19% | 19% |
| Estimated Children in MC with BH treatment need | 150,453 | 148,074 |
| Summary of High Acuity BH Treatment Penetration | | |
| MC Children Using 3+ BH Services | 36,697 | 37,925 |
| Percent of MC Children Using 3+ BH Services | 5% | 5% |
| Treatment Penetration for Children in MC | 24% | 26% |

METRIC DEFINITIONS AND SOURCES

It should be noted that the treatment penetration presented in Figure 4.2 does not include low-level BH treatment when counting the number of annual BH services received. To evaluate treatment penetration rates for low-level BH settings, see the DSHS report published in February 2021. The information presented here is based on services covered through the managed care behavioral health benefit package.

Children in Managed Care

Approximately 800,000 children (ages 0-18) were enrolled in managed care during calendar years 2018 and 2019, based on membership data provided by the HCA, which was used in developing capitation payment rates to MCOs. We have observed that while the total number of children enrolled in managed care decreased between 2018 and 2019, the number of children receiving BH treatment increased.

Behavioral Health Treatment Need

DSHS defines behavioral health treatment need as having at least one MH-related or SUD-related diagnosis, prescription, or treatment recorded in Washington State's Medicaid data system, or an SUD-related arrest record in other administrative data. Treatment needs

can be documented on any type of member claim, including non-BH-related treatment, low-level BH treatment, or services covered under the BH benefit package.

Behavioral Health Treatment Penetration

For the purpose of this request, we identified children (age 0-18) receiving high acuity BH services in at least three months of a calendar year to define BH treatment penetration. Treatment penetration is then calculated as the number of identified children divided by the estimated number of children with a BH treatment need.¹

We relied on this definition of high acuity BH treatment penetration because the data were readily available in a separate analysis of managed care integration savings that is currently in progress for HCA.

ADDITIONAL CAVEATS AND CONSIDERATION

Below are additional caveats and considerations for reviewing the information presented in this attachment:

- i We relied on the broad definition of BH treatment needs from the DSHS report. However, we expect that many children with behavioral health treatment needs may be sufficiently treated in low-level settings of care. To evaluate historical treatment penetration that includes these low-level BH services, see the detailed exhibits in the DSHS report.
- i The treatment penetration presented in this attachment is intended to reflect children receiving higher acuity BH services. We expect the number of children requiring high acuity services under the BH benefit package is significantly less than overall BH treatment needs. We have not developed a methodology to define high acuity treatment needs.
- i The treatment penetration presented in this attachment is based on statewide data from the BHOs and MCOs. A significant number of children were transitioned from BHOs to integrated MCOs between 2018 and 2019.
- i This analysis was based on readily available data from multiple research efforts that were developed with different intended purposes and may not be appropriate to combine.

¹ Note that the number of children in managed care with a BH treatment need was estimated based on the average treatment need rate from the DSHS report.

Caveats and Limitations

The terms of Milliman’s contract with the Washington Health Care Authority signed on December 15, 2017 apply to this report and its use.

This memorandum, including attached exhibits, is intended for the use of the State of Washington, Health Care Authority (HCA) in support of the Medicaid managed care programs and may not be distributed to any third parties without the prior written consent of Milliman. To the extent that the information contained in this report is provided to third parties, the document, including all appendices, should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

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Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used.

This analysis has relied extensively on data provided by HCA and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

References

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milliman.com

CONTACT

Jennifer Gerstorff
jennifer.gerstorff@milliman.com

Daniel Gerber
daniel.gerber@milliman.com

Joseph Whitley
joseph.whitley@milliman.com



Opportunities to Align or Collaborate?

Introduction to the Work of the *Clinical Integration Assessment Tool Workgroup*

CYBHWG Behavioral Health
Integration Subgroup
May 3, 2021

Current Challenge

- ▶ Stakeholders want to understand where our state is with advancing PH/BH bidirectional clinical integration
 - ▶ What does it mean to be integrated?
 - ▶ What providers are integrated and at what levels?
 - ▶ Where are we now – statewide benchmark
 - ▶ How do we track integration improvements over time (in practices, regional and statewide)?
 - ▶ How do we link level of integration to patient outcomes?
- ▶ ACHs and MCOs *have* been working to advance integration with their participating & contracted providers
 - ▶ ACHs are assessing for integration using the MeHAF assessment tool. This tool was not developed with BH providers in mind and although many BH providers have been able to adapt, the tool is not ideal for BH providers and is based on what is now old research.
 - ▶ MCOs have been using a variety of other tools/approaches or not at all.
- ▶ There has been no way to compare data, set benchmarks or improvement goals for the state.
- ▶ ACHs work with their providers and MCOs with their contracted providers, but expectations have not been clear.
- ▶ There has not been a common language around this work and there is potential for significant burden on providers through multiple assessments, different approaches, different parameters.
- ▶ It became clear that before we can move forward, we need a common assessment tool to use across the state, one that works for adult, pediatric, small, large and BH and PH. Tall order!
- ▶ Began a workgroup to review all available tools and select one statewide tool.

Launched a Workgroup-HCA/MCOs/ACHs Collaboration

- ▶ Review and select a clinical integration assessment tool that can be used by behavioral health and physical health (adult and pediatric) outpatient practices
- ▶ Develop a strategic framework for statewide implementation.

Workgroup Members

Co-leadership/facilitation

- ▶ HCA Colette Rush/ Jennie Harvell
- ▶ HealthierHere Susan McLaughlin
- ▶ Molina Victoria Evans

5 Medicaid MCO's

- ▶ Amerigroup Caitlin Safford
- ▶ Community Health Plan of Washington Sylvia Gil
- ▶ Coordinated Care Tory Gildred
- ▶ Molina Victoria Evans
- ▶ United Health Care Dee Brown

ACH appointed reps

- ▶ HealthierHere Susan McLaughlin, Michael McKee
- ▶ Elevate Health Alisha Fehrenbacher, Kimberley Bjorn
- ▶ North Sound ACH Liz Baxter, Nyka Osteen

Specific Workgroup Deliverables

- ▶ Identify a **common tool** to use statewide to assess outpatient BH and PH provider levels of integration:
 - ▶ Allows for statewide benchmarking and a standard way of tracking improvement.
 - ▶ Improves likelihood for understanding levels of integration that lead to improved patient outcomes.
- ▶ Define a **standardized process/logistics (implementation framework)** around distribution, assessment process, data collection and dissemination in order to streamline and reduce duplication
 - ▶ Including roles and responsibilities of various partners (HCA, ACHs, MCOs)
 - Will require collaboration and coordination
- ▶ Determine **how the data** and information that results from the assessment **will be utilized**
- ▶ Recommend a **sustainable mechanism** for ongoing assessment and continuous quality improvement
- ▶ Complete by June **2022**

Phase 1: Selection of Tool - Completed Work

Workgroup Developed Criteria

▶ **These criteria served as a guide for the work group to review/evaluate tools and methods that assesses integration among various provider organizations.**

1. Helps create common language and vision for integration across provider types
2. Assures whole person screening occurs in every setting, regardless of where a person enters the system. Screening includes: MH, SUD, physical health, SDOH – as standard “vital signs” using a patient centered approach
3. Works in both primary care and behavioral health settings (both MH and SUD) to assess for bidirectional integration.
4. Is relevant for all ages and their unique needs
5. Assesses for team-based care as a cornerstone of integrated care
6. Can be used to guide continuous quality improvement – laid out in a way that helps providers advance their level of integration
7. Minimizes burden to providers and supports them in the best way possible
8. Allows for ease of analysis/summarization and understanding of where a provider is with regard to integration and where they want to go relative to advancing integration
9. Is culturally relevant/responsive and centers on equity
 - Tribal partners will be given option to select tool that works best for them and/or opt out of assessment
10. The tool is based on most current best practices for integration
11. Aligns with other HCA and other initiatives that are happening

Process for Selection

- ▶ Workgroup formed in July 2020 and met ~10 times through February 2021 with smaller subcommittee meetings in between.
- ▶ Collected instruments in use: UHC Tool, Molina Tool, MeHAF, Bree Collaborative Framework, SAMHSA Guidelines, UW AIMS Center Framework and a BH/PH tool set out of NYS.
- ▶ Reviewed and Cross Walked current MCO and ACH Assessment tools/processes.
- ▶ Dec/Jan - Subcommittee went deep into each tool (evaluating/scoring) and made recommendation to Work Group.

Where we Landed

Tool Selected by the Workgroup

Continuum Based Frameworks for Integration in Behavioral Health and Primary Care Clinics - New York State's 'General Health in BH Settings' framework, along with its companion 'framework for BH in Physical Health settings'. *(Note: The framework for PH settings was the precursor for the BH framework).*

Refer to:

- ▶ Advancing Integration of General Health in Behavioral Health Settings

Brief: https://www.thenationalcouncil.org/wp-content/uploads/2020/08/GHI-Framework-Issue-Brief_FINALFORPUBLICATION_7.24.20.pdf?daf=375ateTbd56

Webinar: <https://www.thenationalcouncil.org/webinars/advancing-integration-in-community-behavioral-health-using-a-new-general-health-integration-framework/#:~:text=Through%20advancing%20general%20health%20integration%2C%20community%20behavioral%20health,improve%20patient%20outcomes%20and%20achieve%20substantial%20financial%20savings>

- ▶ Evaluation of a Continuum-Based Behavioral Health Integration Framework Among Small Primary Care Practices in New York State.... to access assessment tools and descriptions.

Report: https://uhfnyc.org/media/filer_public/61/87/618747cf-9f4b-438d-aaf7-6feff91df145/bhi_finalreport.pdf

The Tool Stands Out in Comparison

- ▶ The workgroup members agree that this tool would best serve to advance bidirectional integration in Washington state. The recommendation was reviewed with ACH/MCO/HCA leadership and selection was confirmed.
 - ▶ Developed in 2019 and 2020 - uses current language and concepts.
 - ▶ Developed by BH and PH providers respectively and road tested in both PH and BH settings.
 - ▶ Meets all the criteria set by the workgroup.
 - ▶ The tool is structured as a continuum-based framework – serves as a road-map for integration steps.
 - ▶ Initial research work done with the physical health version...used in hundreds of practices across NYS.
 - ▶ BH providers asked that a similar framework be developed for BH settings.
 - ▶ For BH Settings, exhaustive literature review looking at all RCTs and implementation studies in past 20 years.
 - ▶ For those domains not in the literature, they used clinical judgement and clinical consensus.
 - ▶ Road tested with 1:1 stakeholder interviews; interviews with larger policy groups and provider groups.
 - ▶ Tested with a smaller group of BH providers with additional testing planned through National Council of BH.

Reviewed with Experts

- ▶ Dr. Henry Chung – researched/developed the assessment tool
 - ▶ Tool is in public domain (just need to credit)
 - ▶ Further research to be sponsored by the National Council of BH
 - ▶ Can make tweaks as needed for tailored use
- ▶ Meeting with Dr. Kerns: UW AIMS
 - ▶ Very familiar with tool, likes it and thinks it would be a good direction
 - ▶ Feels (along with Vicki and Tory) there is applicability for both pediatrics and SUD (maybe with minor tweaks)
- ▶ Addressed with BREE Collaborative staff
- ▶ All indicated the importance of defining how we will use the data and making sure it is connected to outcomes

Framework Domains & Subdomains



1. Screening, referral to care, and follow-up

- 1.1 Screening and follow-up
- 1.2 Facilitation of referrals



2. Evidence-based care for preventive and general medical conditions

- 2.1 Use of guidelines or treatment protocols
- 2.2 Use of targeted medications by behavioral health prescribers
- 2.3 Trauma informed care



3. Ongoing care management

- 3.1 Longitudinal clinical monitoring and engagement



4. Self-management support adapted to patient

- 4.1 Use of tools to promote patient activation and recovery

Framework Domains and Subdomains



5. Multi-disciplinary team (including patients) with dedicated time

- 5.1 Care team
- 5.2 Sharing of treatment information, case review, care plans and feedback
- 5.3 Integrated care team training



6. Systematic quality improvement

- 6.1 Use of quality metrics for physical health program improvement and/or external reporting



7. Linkages with community and social services

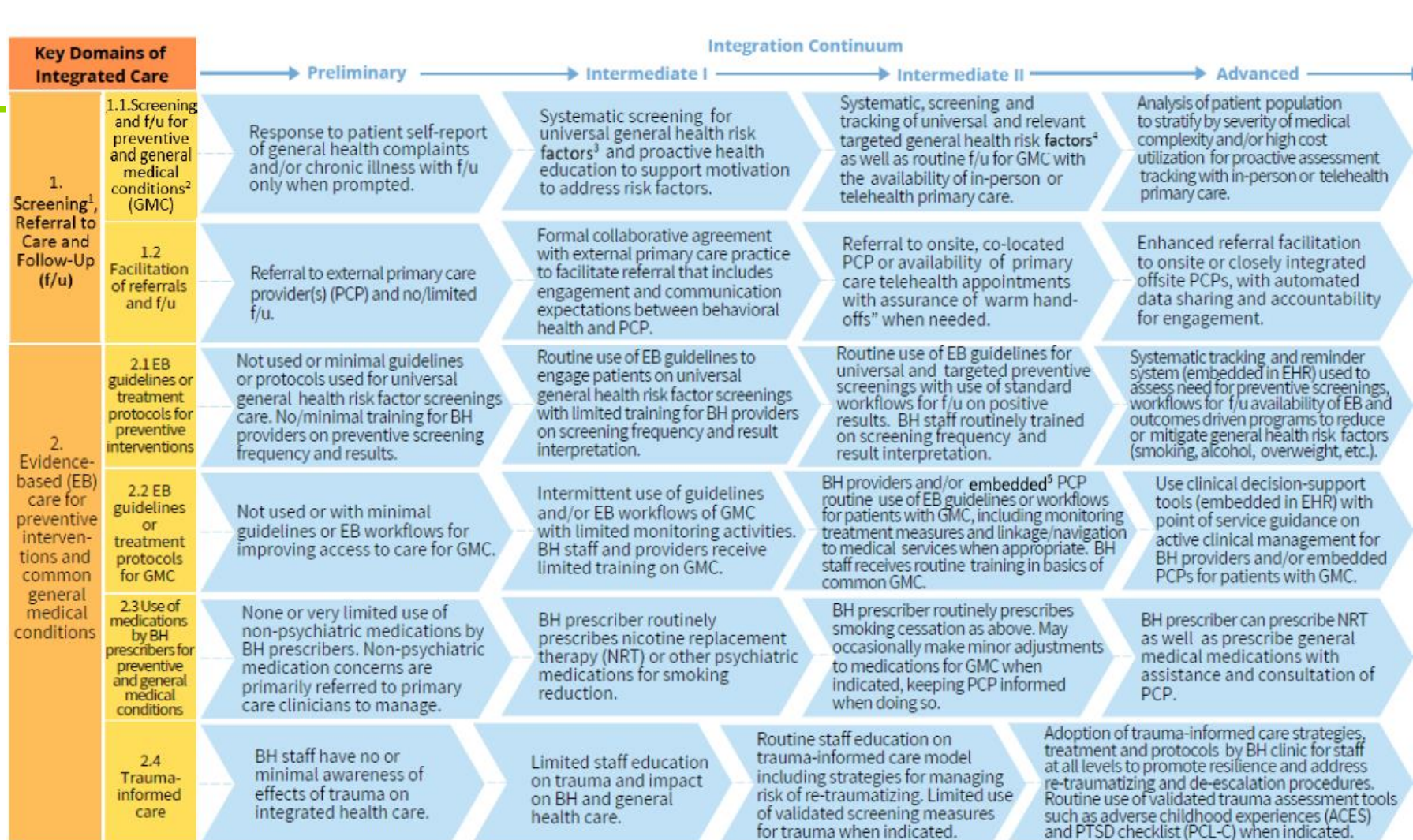
- 7.1 Linkages to housing, entitlement, other social support services



8. Sustainability

- 8.1 process for billing and outcome reporting
- 8.2 process for expanding regulatory and/or licensure opportunities

Snapshot of Actual Assessment Tool



Phase 2 – Current Work

Received HCA HIT Funding March-June

- ▶ To conduct pilot with broad group of providers (SUD, MH, Rural, Urban, Adult, Pediatric).
- ▶ To begin to develop an implementation framework.

Pilot to Gain Experience

- ▶ Testing the tool across different provider types
 - ▶ Will obtain feedback about use including:
 - ▶ any needed modifications
 - ▶ how best to support practices in the transition to new tool
 - ▶ logistics around training and T/A for completion of tool - especially interested in feedback from SUD and pediatric practices
 - ▶ Will consider whether we need to add questions at end (i.e., frequency in screening; greater clarity about what is screened for; etc.)

Co-create an Implementation Framework

The details regarding the administration/collection/analysis/distribution of a statewide, standardized tool:

Such as:

- ▶ How will stakeholders (HCA, ACHs, MCOs) coordinate in support of the work?
- ▶ Who is assessment submitted to (centralized, regional)?
- ▶ Who compiles and analyzes the data?
- ▶ How is the data shared among key stakeholders?
- ▶ How will the data be used to advance the system?

Phase 3 – Framework for Provider Support - 2022

- ▶ Outline roles and responsibilities of ACHs/MCOs in providing coordinated and collaborative support to providers for quality improvement.

Opportunities for Alignment and Collaboration?

▶ Next steps?



Questions?

Colette Rush, BH/Nurse Consultant
Health Care Authority
colette.rush@hca.wa.gov

Memorandum

To: Jennie Harvell, Senior Federal Project Consultant – HCA
Colette Rush, Behavioral Health Clinical Consultant, - HCA

From: Susan McLaughlin, Executive Director, HealthierHere

Date: March 15, 2021

RE: Integration Assessment Pilot - Report on Organizations and Sample Contract

HealthierHere has chosen six partners to participate in the Integration Assessment Pilot study. All partners have signed contracts with HealthierHere (sample attached), and all will begin their formal participation in the pilot on Tuesday, March 16, 2021 with an introductory webinar hosted by, Dr. Henry Chung, the lead developer of the Continuum-Based Frameworks for Integration in Behavioral Health and Primary Care at Montefiore Health Systems in New York. The six pilot organizations working with HealthierHere are:

1. Consejo Counseling and Referral Service

This smaller provider of mental health and SUD services offers a wide variety of programs for adults, youth, and families, serving mostly the Latinx and Spanish-speaking population in King, Pierce, Mason and Thurston counties. For this pilot, Consejo will be engaging with their Thurston county clinic location to help provide a rural and culturally tailored service provider perspective.

2. Ideal Option

This large organization, located in 10 states, has locations across the state of Washington in rural, suburban, and urban settings. They specialize in medication-assisted treatment for addiction to opioids, alcohol, and other substance use disorder (SUD). Ideal Option will be focusing the study on their clinic in Mount Vernon, WA.

3. Sea Mar Community Health Centers

This large federally qualified, community health center (FQHC) has locations in 13 counties in Washington, and has a particular focus serving the Latinx and Spanish-speaking populations. For purposes of this study, they will be focusing on their Vancouver location, to provide another suburban perspective. They are experienced with behavioral health integration at their primary care clinics, as well as through their behavioral health locations. They will be representing the FQHC primary care perspective.

4. Skagit Pediatrics

This mid-size provider of pediatric primary care services in Mount Vernon, WA, has been recommended by several members of the Integration Assessment Workgroup, due to their activity and experience with behavioral health integration. They have engaged with North Sound ACH and received from consultation from the UW AIMS Center. Additionally, they are a participating provider in HealthierHere's

Testing Models for Integrated Care partnership between Seattle Children’s Care Network and Seattle Children’s. They will bring the pediatric primary care perspective.

5. Quality Behavioral Health

This smaller provider of behavioral health and SUD services to adults and youth is based in Clarkston, WA, and serves Asotin and Garfield Counties in Eastern Washington. They were recommended to HealthierHere for this study by the Greater Columbia ACH based on their experience with helping to provide integrated care. They will be bringing a smaller, rural BHA perspective.

6. Valley Medical Center

Valley Medical Center (VMC) is the largest nonprofit healthcare provider between Seattle and Tacoma, serving over 600,000 residents. In addition to the hospital, the Medical Center operates a network of more than two dozen primary care, urgent care and specialty clinics. VMC’s primary care clinic in Kent, WA will be the focus of this integration assessment study bringing the hospital – based primary care perspective.



BRIDGE OF HOPE

BEHAVIORAL HEALTH INTEGRATION AT THE PEDIATRIC MEDICAL HOME

May 3, 2021
Behavioral Health Integration Subgroup
Children and Youth Behavioral Health Work Group
HopeSparks and Pediatrics Northwest



SPEAKERS

- **Joe LeRoy**, LICSW, President and CEO — Hope Sparks
- **Mary Ann Woodruff**, MD, FAAP, Director of Behavioral Health Integration — Pediatrics Northwest
- **Wendy Pringle**, LMHC, Director of Pediatric Healthcare Integration — HopeSparks

Our Story

HopeSparks and Pediatrics Northwest

STATEWIDE SIGNIFICANCE

- 1 in 5 children & adolescents experience a mental health disorder annually, but 80% do not receive treatment.
- Washington state ranks 43rd in the U.S. for children & adolescent's access to BH care.
- Less than half of children and adolescents referred for specialty behavioral health services actually see a therapist, and then many of those only go once.

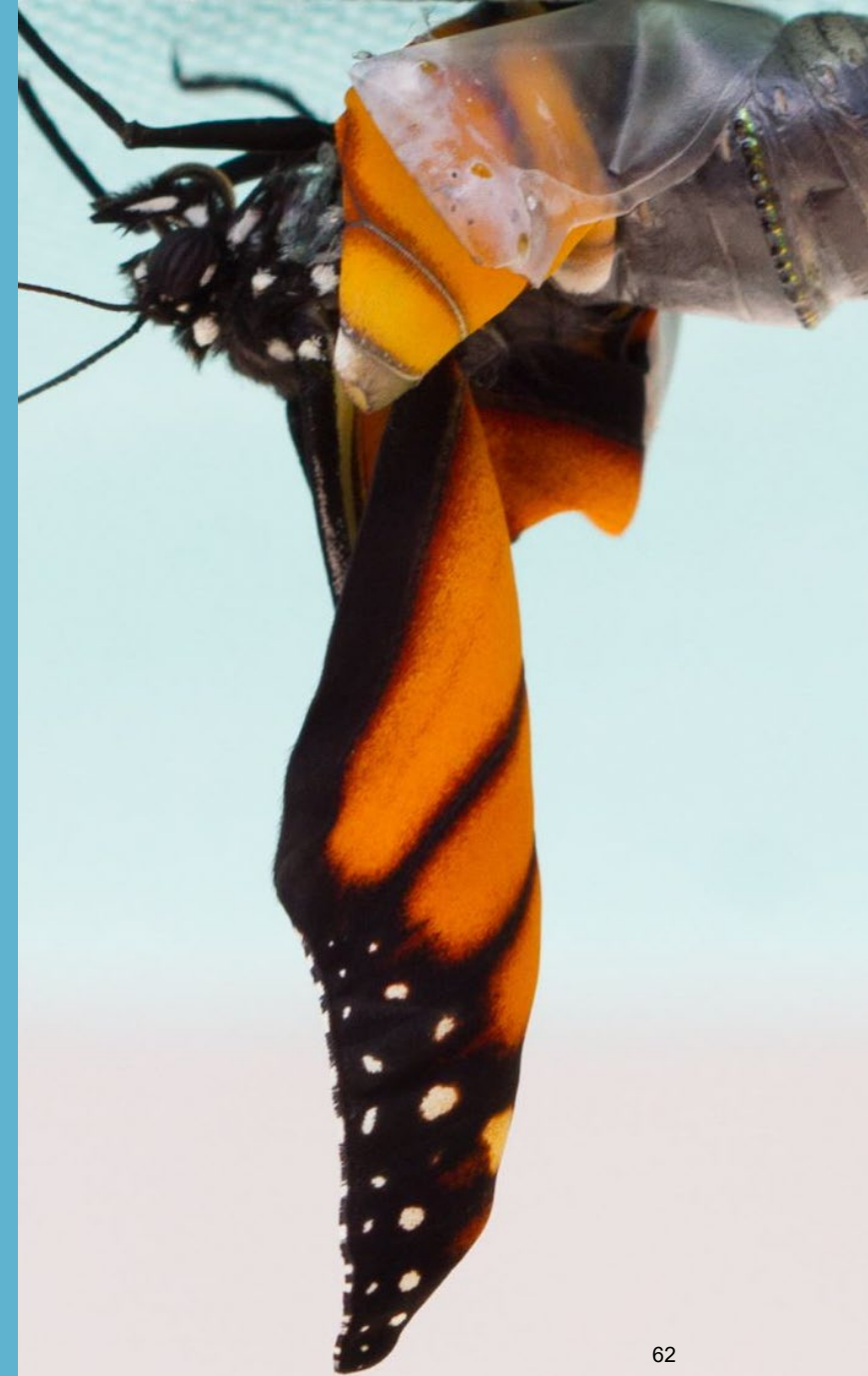
STATEWIDE SIGNIFICANCE

What Can Be Done?

- Behavioral health integration for children in primary care is the right resource at the right time — early, when a need first presents.
 - Breaks down stigma & logistical barriers for families
 - Builds on trust in the PCP
 - Gets kids fast help in evidence-based and time-limited ways
 - Maximizes the workforce and supports pediatric medical providers and family practice
- Pediatrics NW and HopeSparks are taking this model even further — to support behavioral health through the *life course*.

**“YOU NEVER CHANGE THINGS BY
FIGHTING THE EXISTING
REALITY. TO CHANGE
SOMETHING, BUILD A NEW
MODEL THAT MAKES THE
EXISTING MODEL OBSOLETE.”**

- R. Buckminster Fuller



**“EVERY BABY CAN HAVE A
CHANCE FOR LIFE. EACH ONE
CONTAINS ALL THE POTENTIAL
POSSIBILITIES OF ALL HUMANITY.
WHATEVER THE STATISTICS SAY,
EACH HAS A RIGHT TO LIVE. AND
EACH CAN LIVE.”**

Josephine Baker, MD (1873-1945)

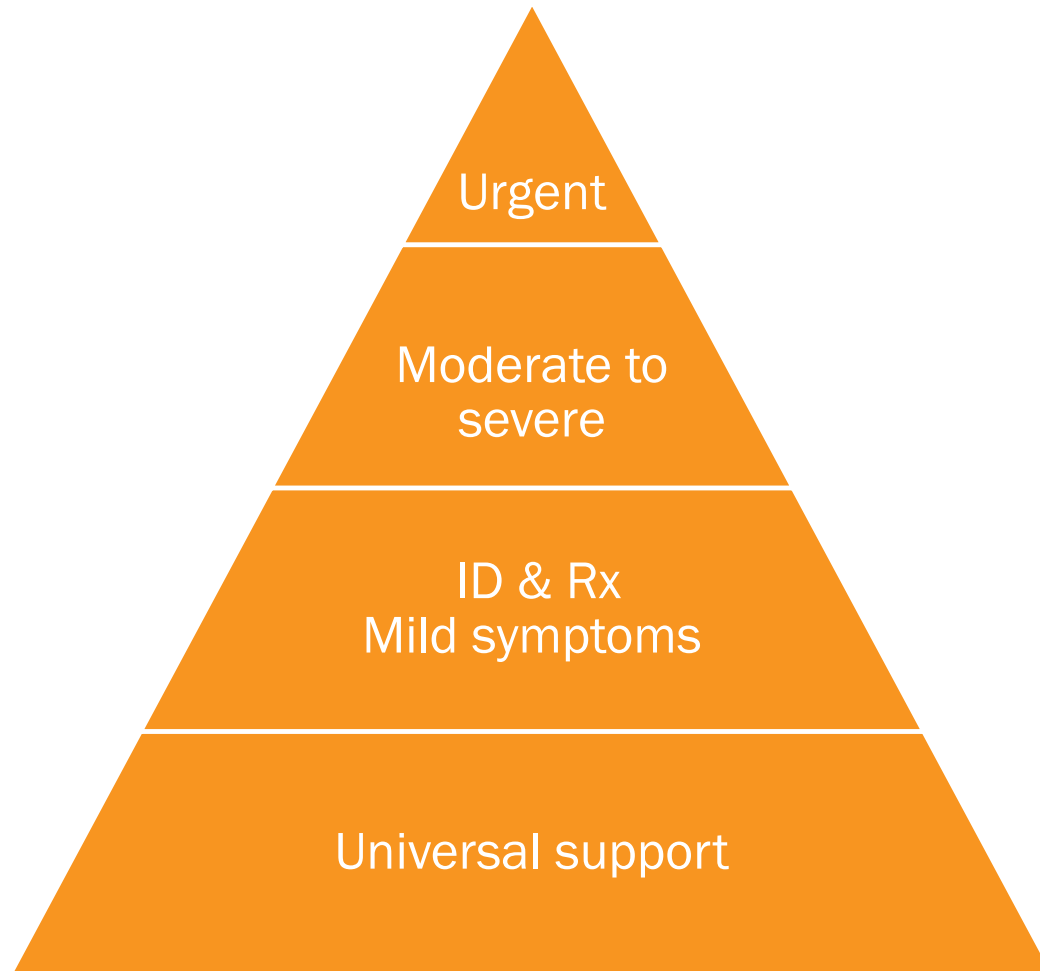
- A Good Time to Be Born, How Science and Public
Health Gave Children a Future by Perri Klass, MD



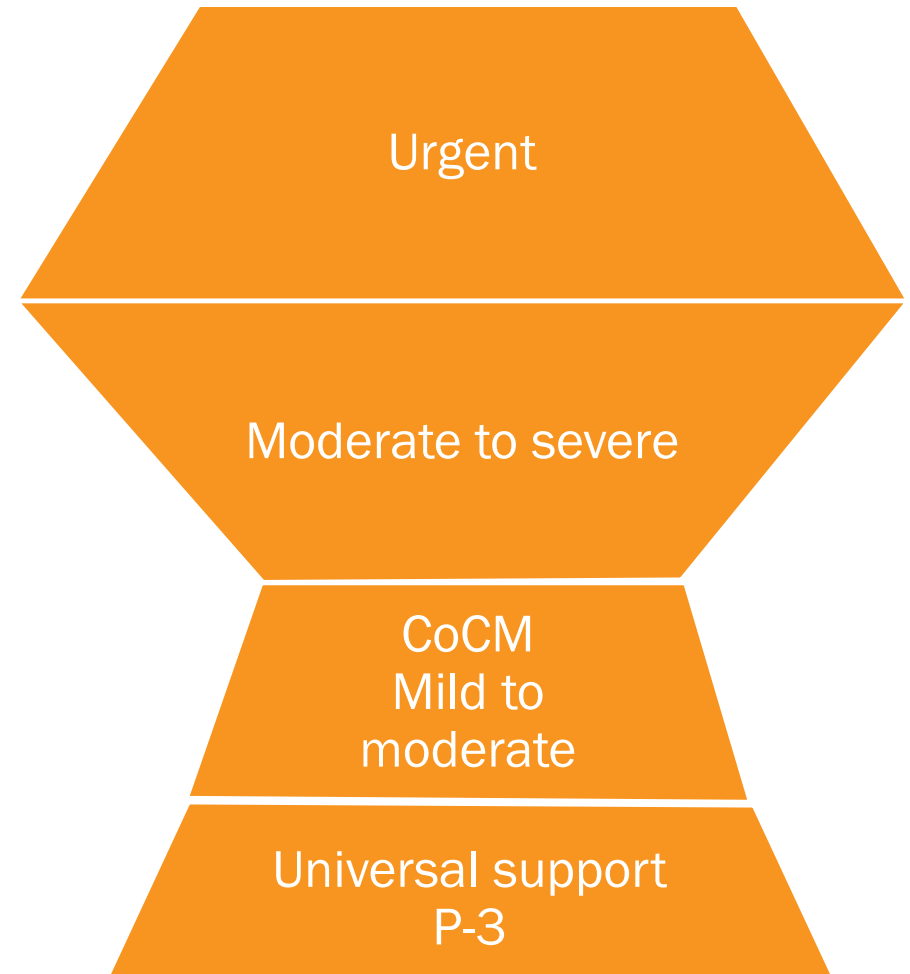
Regular Days

(or Anything but Regular)

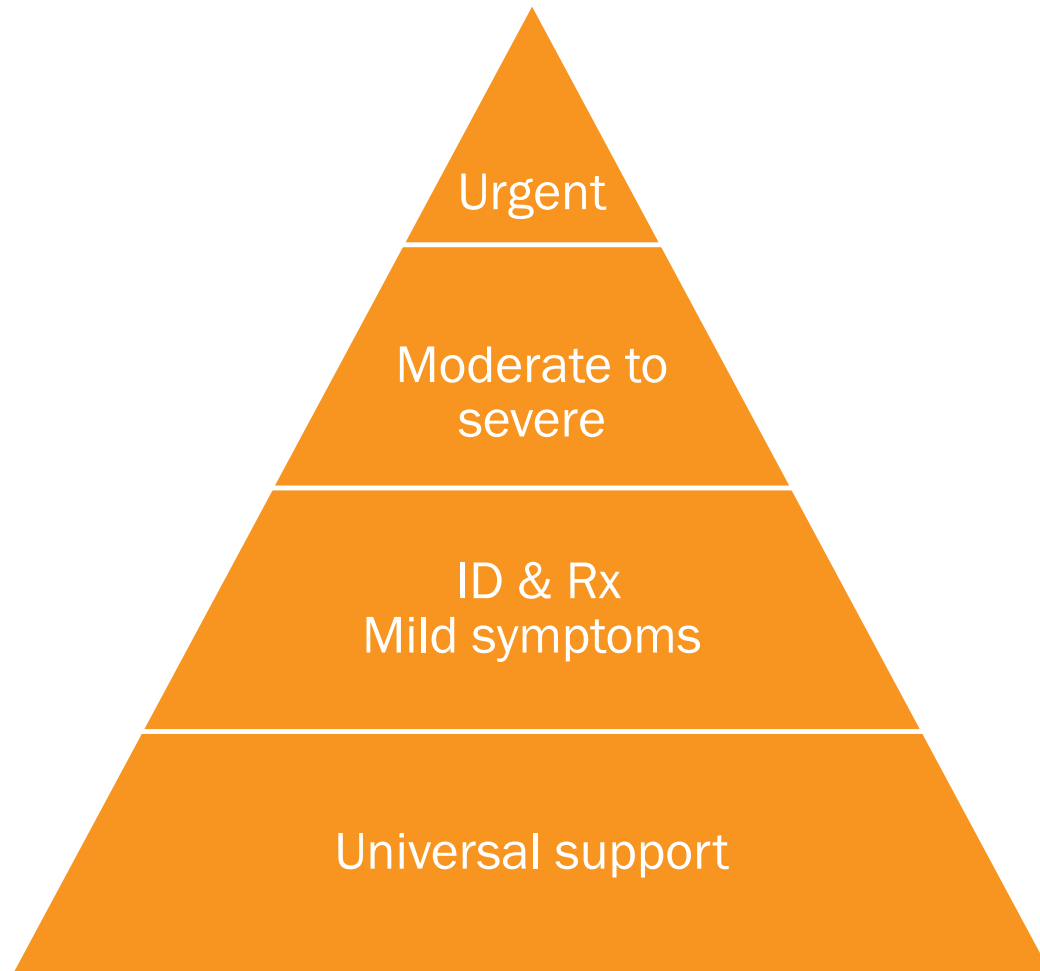
STEPPED CARE STRATIFICATION



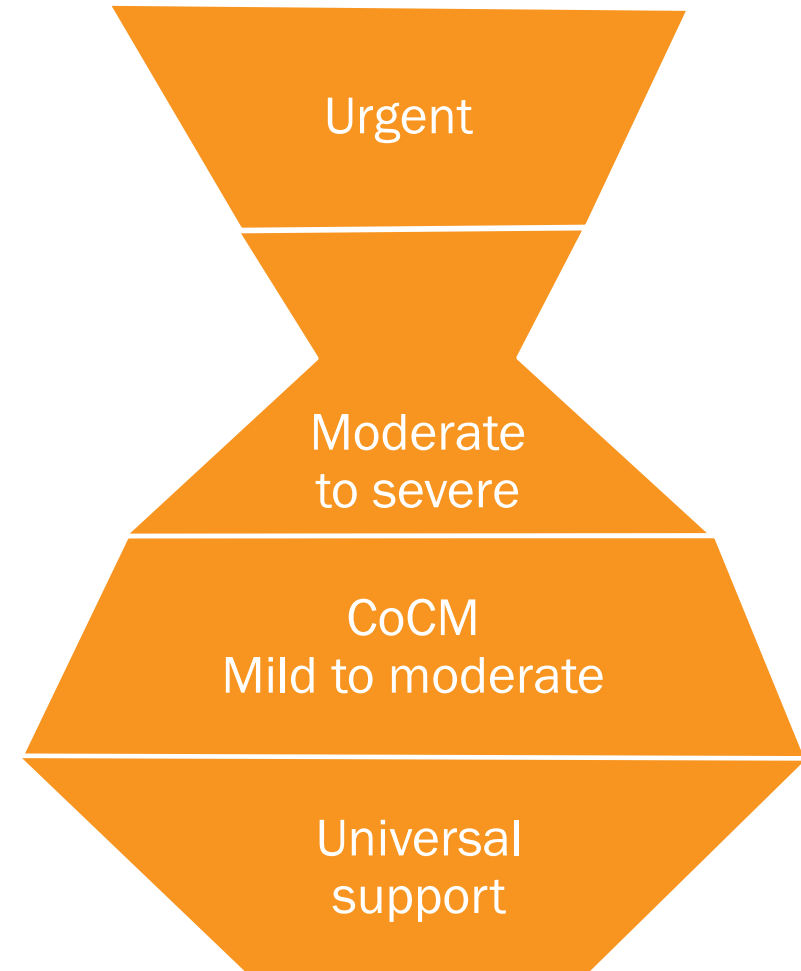
ACTUAL



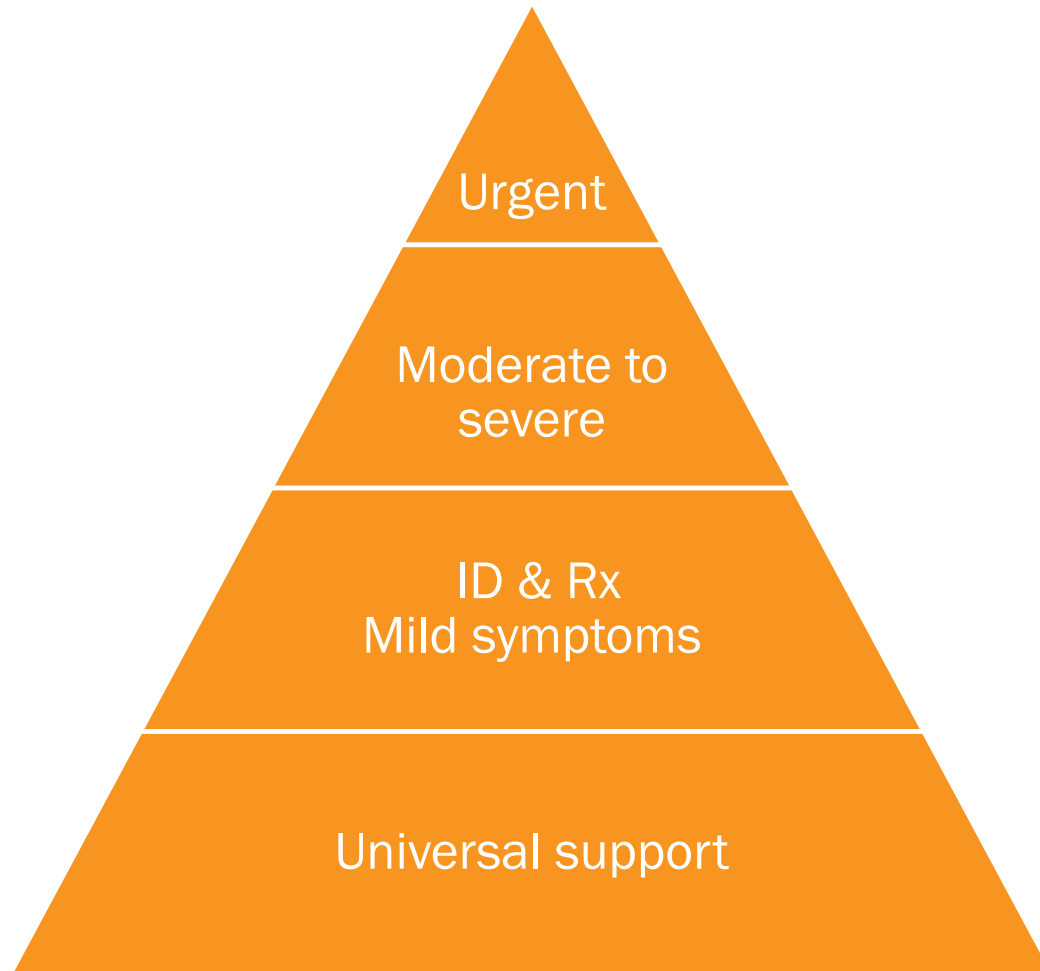
STEPPED CARE STRATIFICATION



CONNECTIONS TO CARE



STEPPED CARE STRATIFICATION



CAPACITY



**“NONE OF US
IS AS SMART AS
ALL OF US.”**

- University of Washington AIMS Center



FROM THE BEGINNING



Power of
Prevention



Early
Identification



Early
Treatment

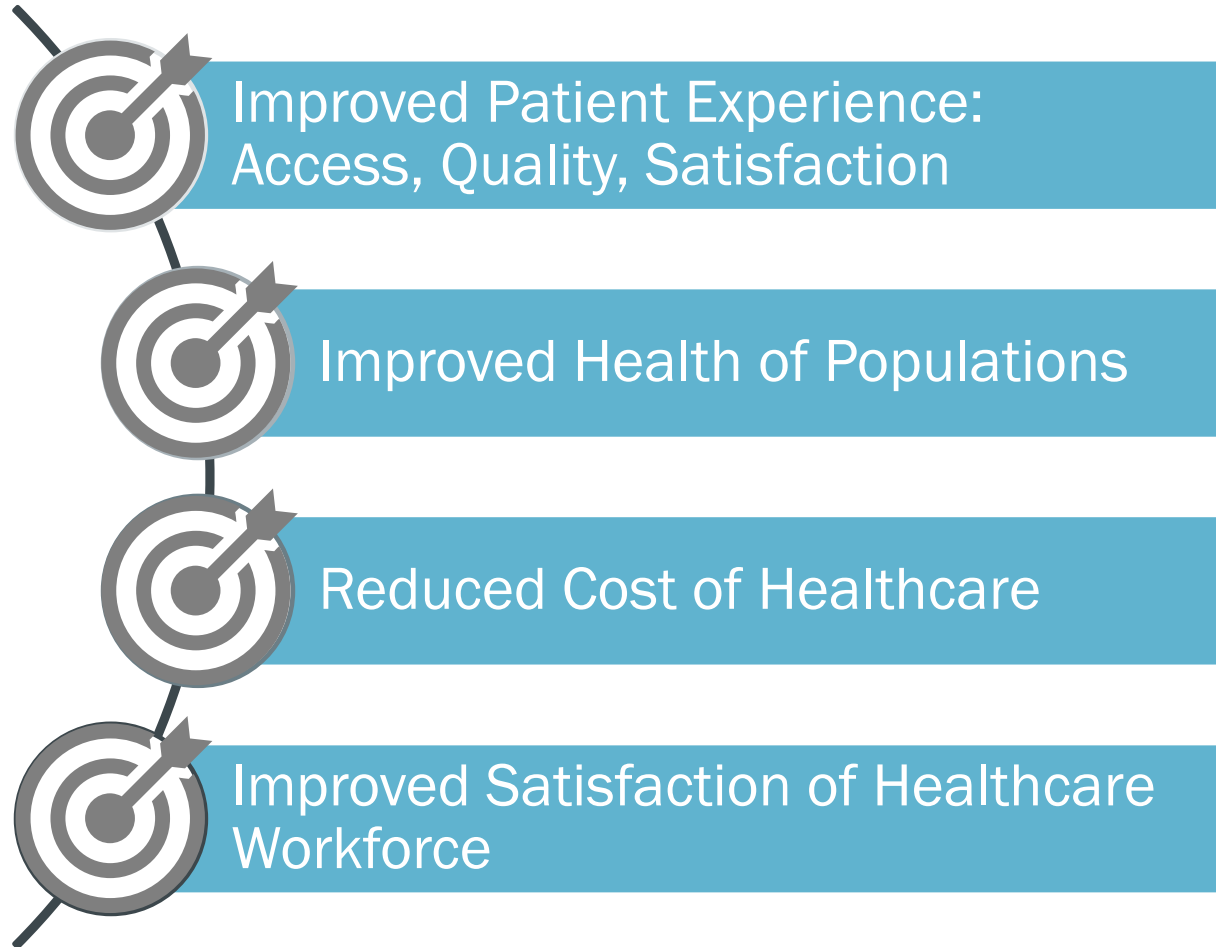


A Team
Approach

THE POSSIBILITIES WHEN WE GET THIS RIGHT

- Two-thirds of teens with depression identified and treated
- Decline in suicide rate
- Treatment outcomes improve
- Shift from costly episodic and crisis care

THE QUADRUPLE AIM

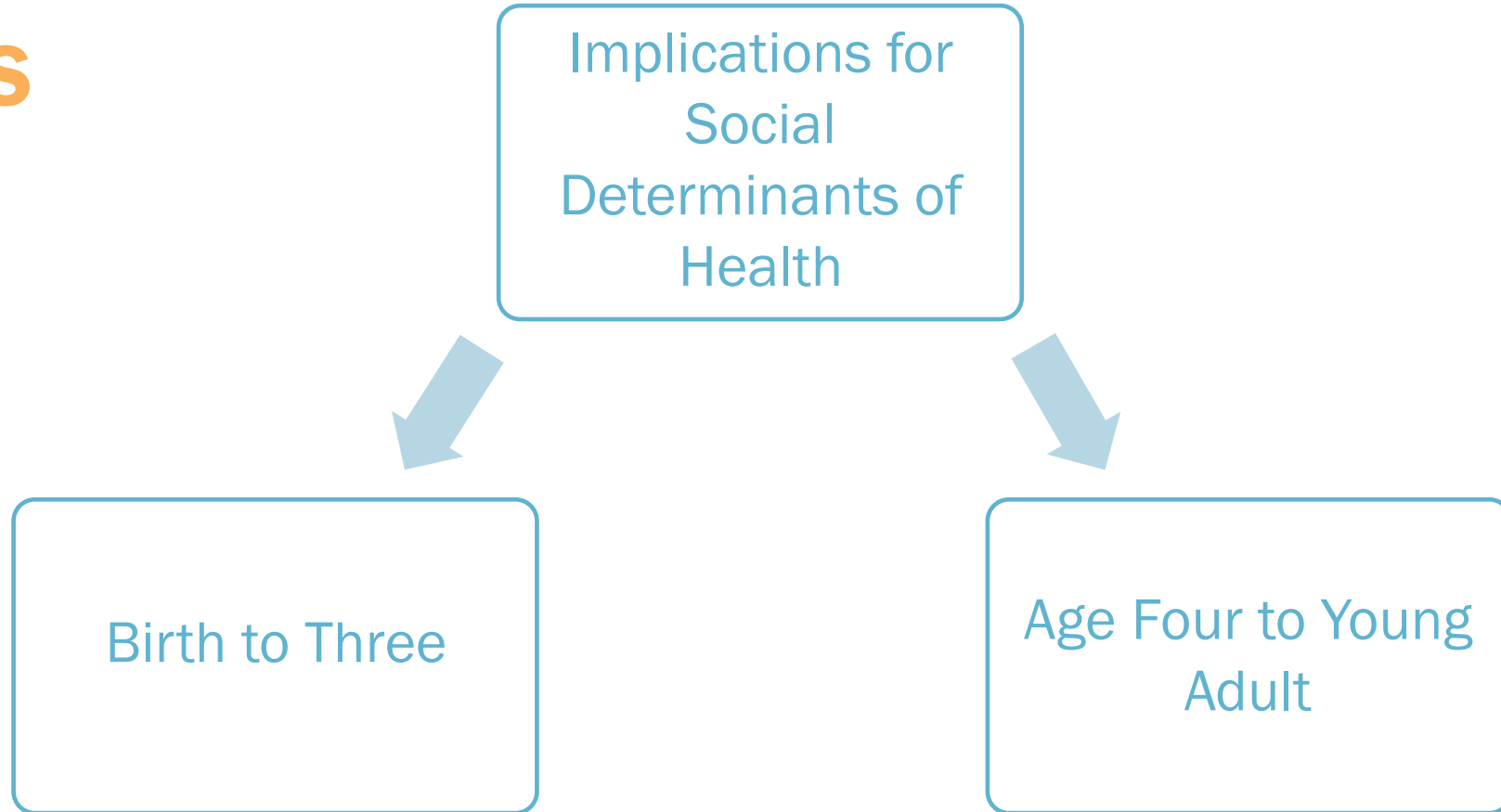


DO ASK, DO TELL

- We DO ask and we say to patients, “Do Tell”
- How? ... With universal screening



DEFINING CARE PATHWAYS



BIRTH TO THREE

- Creating a Mindset: Early Relational Health
- Screening for Perinatal Mood Disorders
- Screening for Infant Social and Emotional Wellbeing
- Surveillance with Reach Out and Read and Promoting First Relationships
- Utilizing the Early Intervention System (ESIT)
- Connection via Help Me Grow

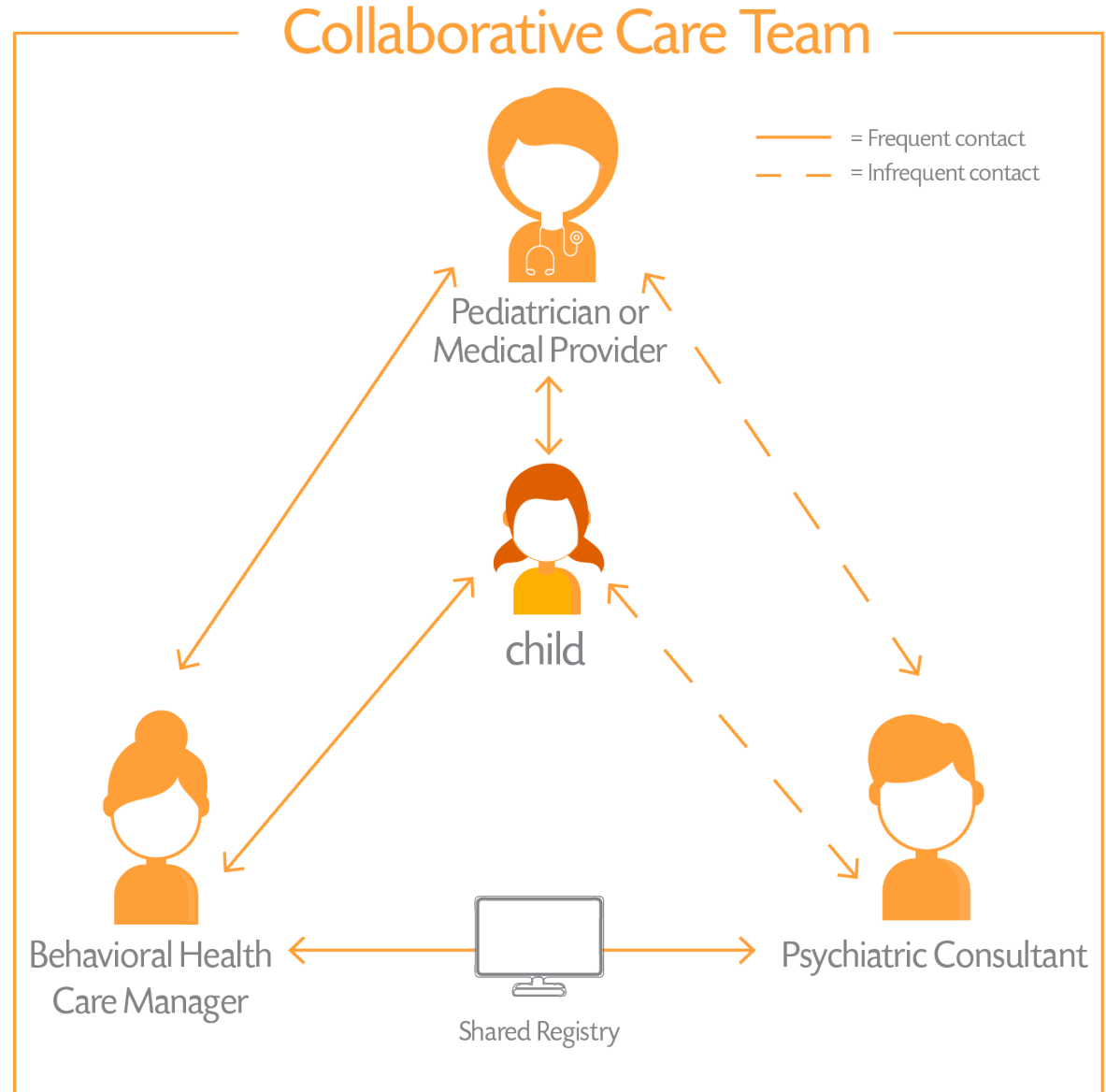


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THE COLLABORATIVE CARE MODEL (CoCM)

- The AIMS Center
- Ages 4-21 years
- Universal mental health screening at well child visits
- Team approach at the medical home
- Evidence based care
- Tracking engagement and progress on a registry
- Billing collaborative care codes

THE COLLABORATIVE CARE MODEL EXPLAINED



KEY PRINCIPLES OF COLLABORATIVE CARE

- Patient Centered Team Care
- Population Based
- Treatment to Target
- Evidence Based
- Accountable



OUR TIMELINE

2018-2019

- Catalyst Grant award
- Three year project plan
- Team development
- Created workflows
- Chose screening tools
- Created trainings
- Hired first Behavioral Health Care Manager

2020

- Started with one pediatrician, one Care Manager March 2020
- Expanded CoCM across 1 of 4 Pediatrics Northwest offices Summer
- Telehealth critical to this work
- Hired second and third BHCMS
- Expanded to second Pediatrics Northwest clinic
- Continued workflow and education development
- Cross sector work: Pierce County Help Me Grow, 211, SDOH, Washington Chapter of the American Academy of Pediatrics, IHI

OUR TIMELINE

2021

- Completed expansion across second Pediatrics Northwest clinic
- 11 pediatricians and 3 Behavioral Health Care Managers currently participating in CoCM
- Anticipate expanding across entire practice 2021 (27 pediatric practitioners)
- Universal behavioral health screening at all well child visits (alignment with WA EPSDT requirements)
- Continue to expand and hone workflows
- Collaboration with community to develop closed feedback loops for referral to Specialty Care
- Financial Modeling/Sustainability

SO FAR ...

- We started during the Pandemic
- Soaring rates of depression and anxiety
- Behavior concerns abound
- Loss of support
- Material needs

Our data shows promise

THE DATA: ACCESS

From primary care referral to first contact with Behavioral Health Care Manager



2.23 calendar days

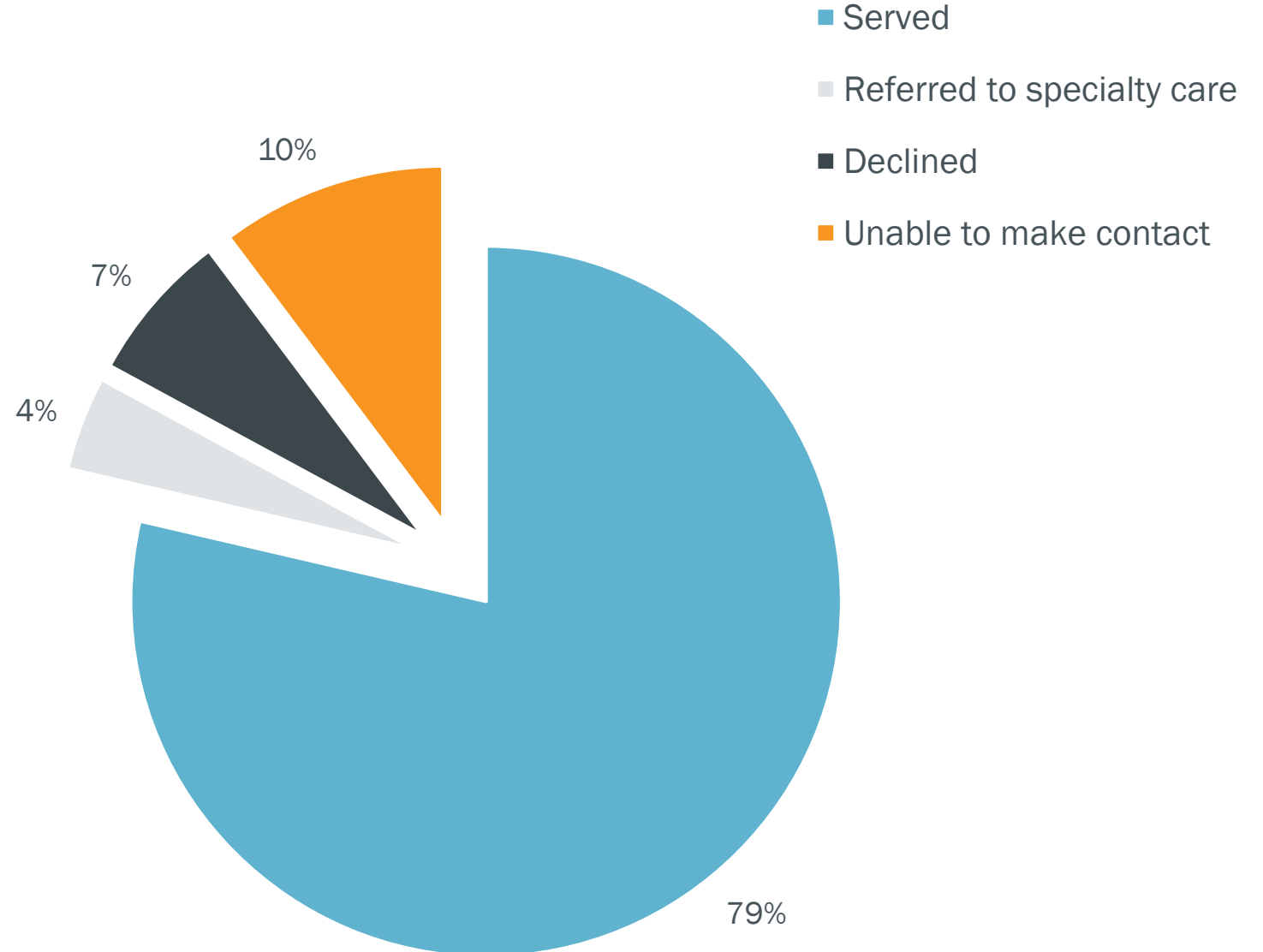
ZERO

THE DATA: OUTCOMES

234 Patients Referred

(end of March 2020 to end of
March 2021)

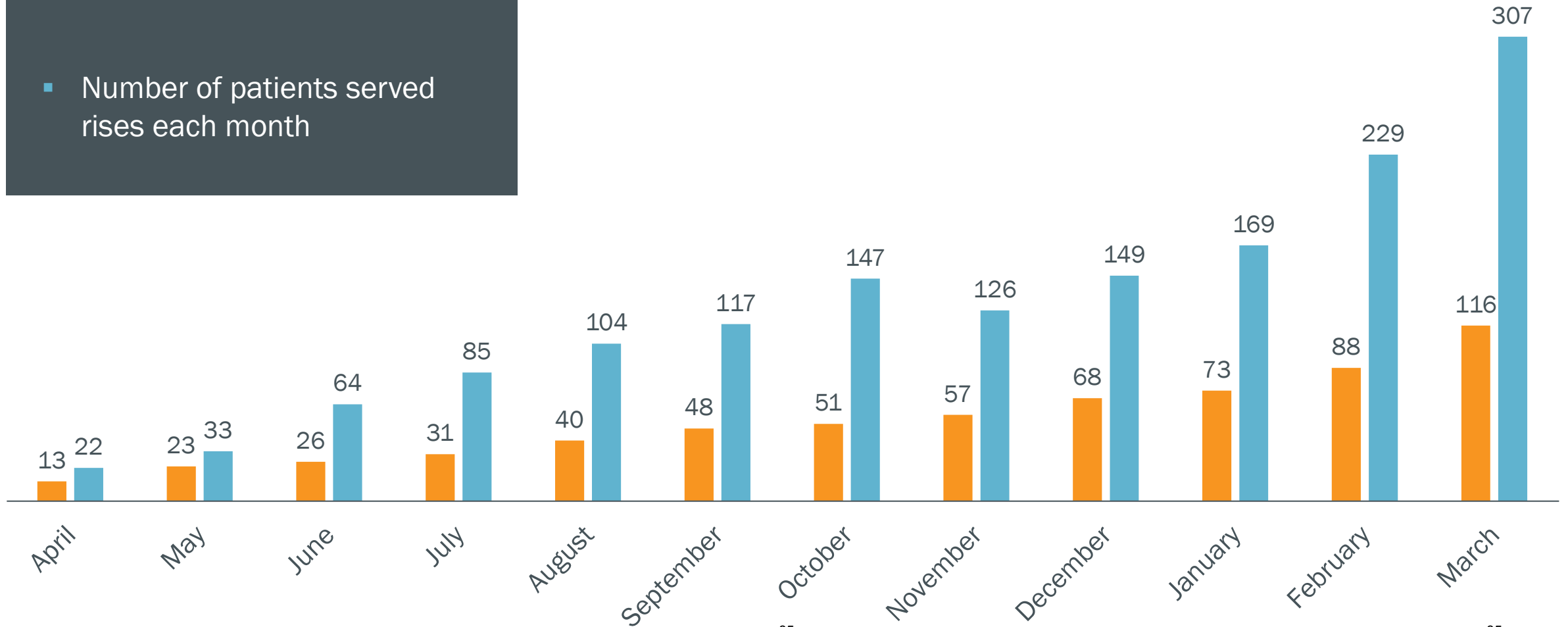
- 184 served
- 10 referred to specialty care
- 16 declined
- 24 unable to make contact
- 70-80% improvement rate for children in CoCM for at least 1 month



THE DATA: OUTCOMES

- Number of patients served rises each month

Patients Therapy Sessions



SUSTAINABILITY

- Sustainability need not depend upon simply the billing success for CoCM
- The current reality is NOT sustainable

DULY NOTED

None of the CoCM enrolled children had ED visits for mental health concerns while in treatment



LESSONS LEARNED

- CoCM has triage capabilities
- Access to care is vastly improved with CoCM
- As access is improved, equity is addressed
- When help is offered, families embrace it
- Team work is powerfully good
- CoCM addresses scarcity of resources
- Care team gets better and better

- “I didn’t know how much these worries were taking up my time!” from a teenager completing her treatment in Collaborative Care

THE REALIZATION OF HOPE

- Human learning occurs in the context of relationships
- Cost savings and reinvestment
- Physicians and therapists are more productive, effective, happier
- Right care at the right time in real time

**“CHANGES WILL NOT COME
IF WE WAIT FOR
SOME OTHER PERSON
OR IF WE WAIT
FOR SOME OTHER TIME.
WE ARE THE ONES
WE’VE BEEN WAITING FOR.
WE ARE THE CHANGE
THAT WE SEEK.”**

- BARACK OBAMA

May 3, 2021 Behavioral Health Integration Subgroup

Chat log (edited)

Bob Hilt: Just a current update on the Mental Health Referral Service -- the legislature and HCA have found funding for two additional surge positions which will bring the wait time down. But right now as Mary Ann said it is taking over a month before parents are getting the full matching assistance. Once the specialist is actively working a case, they are finding a provider within about 7 days on average.

Question: Are the limitations on BH needs that the Collaborative Care model can address?

- **Wendy Pringle:** *We target those with mild to moderate health needs. Those who need longer sessions and more specialty care such as HopeSparks Behavioral Health.*

Nat Jungbluth: For those interested in learning more about First Approach Skills Training (FAST) programs, our materials are freely available here: <https://seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/pal-plus/>

- **Sarah Rafton:** *We are hoping, Nat, that you and or Erin can present the FAST model in the coming 1-2 mos. Just want to set our upcoming meeting dates and then will reach out to you.*
- **Bob Hilt:** *Just as another FYI for the group, the "FAST" treatment protocols that are being referenced and Nat will share in the future were developed with HCA and state legislature funding in the "PAL Plus" project for which we thank the state's support in this effort.*

Sarah Rafton: Kristin and I will get future meeting dates to you as soon as possible. I believe it will be 2 meetings in June, 1-2 in July, 2 in August.