

Medicaid Integrated Purchasing for Physical and Behavioral Health: Effects of Payment Reform
on Provider Organizations in Washington State

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Abstract

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Background: The Center for Medicare and Medicaid Innovation (CMMI) was established by section 1115A of the Social Security Act, which gave rise to the State Innovation Models (SIMs). Medicaid integrated purchasing for physical and behavioral health, also known as Payment Model 1 (PM1), is a core payment redesign area of the Washington State Innovation Model project.

Purpose: The aim of this study was expand understanding on the effects of the PM1 initiative on payer and provider organizations in the region through the lens of a conceptual framework.

Methodology: The evaluation team conducted eight qualitative key informant interviews with twelve healthcare executives representing payers and providers engaging in PM1 under the SIM initiative.

Results: Mapping results to an evidence-based conceptual framework shows emergent themes of care integration, connections to the Triple Aim, common facilitators and barriers of integration, and a potential concern for sustaining the initiative into the future.

Conclusion: Evaluation of PM1 and clinical integration efforts requires extensive consideration of provider and managed care organization (MCO) needs and practice-based integration techniques. Integration evaluation depends on both internal and external contributing factors, which inform and guide changes to a focused evaluation framework.

Practice implications: Future behavioral and physical health payment integration development in Washington state must consider the impacts on care coordination, partnerships, funding sources, and regional leadership to ensure sustainability of the payment model.

Introduction

The Triple Aim is a framework designed by the Institute for Healthcare Improvement (IHI), aimed at enhancing health system performance.¹⁻³ The IHI Triple Aim is defined by three components: Improving population health, improving quality of care, and reducing per capita healthcare costs.^{2,3} Section 3021 of the Affordable Care Act (ACA) altered section 1115A of the Social Security Act, establishing the Center for Medicare and Medicaid Innovation (CMMI).^{4,5} As a result, the Medicaid and Medicare programs can test models to improve care, lower cost, and support patient-centered practice.⁴ The State Innovation Models (SIM) Initiative is one of the major reform models aimed at testing new payment methodologies to achieve the Triple Aim.⁶

The Washington State Innovation Model Payment Model 1 catalyzes the transition from the traditional Medicaid payment system to a fully integrated managed care model through integration of physical and behavioral health payment to enhance patient-led changes within the processes and structures of managed care organizations⁷. The SIM serves as a blueprint to meet the aims and objectives of the Healthier Washington Initiative. The goal is to integrate behavioral health benefits into the Apple Health Managed Care program so that clients have access to the full complement of physical and behavioral health services through a single fully integrated managed care plan.⁸ Clark and Skamania counties, also called the Southwest Region, constitute the “early adopter” of this payment model which serves as a precursor to the 2020 Statewide Healthier Washington Medicaid Fully Integrated Managed Care (FIMC) system.⁹ Beginning April 1, 2016, for Clark and Skamania, services began to be delivered via two fully integrated managed care plans⁹. Mid-Adopter regions began to transition in January 2018, with eventual statewide rollout of integration planned for 2020.

To evaluate the effects of the SIM Initiative, the state of Washington employed a team at the University of Washington led by Douglas Conrad, PhD of the Department of Health Services and included senior faculty expertise in health economics and finance, organization and management, program evaluation, information technology, population health, and epidemiology. This team was responsible for the qualitative evaluation of the PM1 initiative. The University of Washington team's primary focus of the PM1 qualitative evaluation: ***To examine how payment reform affected provider organizations in Southwest Washington involved in the early adoption of Medicaid integrated purchasing.*** An understanding of the national policy landscape and Washington State's involvement is crucial to support this exploration.

Background

The National Stage

CMMI was established by the ACA to test the impact of innovative health care payment and delivery models on cost and quality of care.¹⁰ In response to the national push for changes in Medicaid service delivery and cost containment, the state of Washington pursued a mission to transform health for Washingtonians known as the Healthier Washington Initiative.¹¹ One of the largest ventures on the national level has been to support Medicaid FIMC. Currently 15 states have implemented Medicaid FIMC.¹² The State Innovation Model program is a CMMI initiative that drives the shift to 80% of care from volume-based to value-based arrangements, a primary goal of the Healthier Washington Initiative.¹³

Washington State's Integrated Purchasing Landscape

One of eleven \$64.9 million SIM Round 2 Model Test awards was awarded to Washington State to implement a statewide strategy to decrease the cost of care, improve population health, and deliver coordinated care.¹⁴ As a result, Washington State is changing how it pays for

physical and behavioral health care, an initiative known as Value-Based Purchasing.¹⁵ Part of this initiative includes the way Behavioral Health and Physical Health are contracted and paid for. This integration of physical and behavioral health payment is designed as a stepping stone towards service integration in the hopes that WA can move toward complete coordinated care for Medicaid physical and behavioral health services.

PM1 is part of a larger context of SIM payment reform by the Health Care Authority (HCA) that aims to move 80 percent of the state-funded health care market from traditional fee-for-service to integrated, value-based payment models.¹³ Four payment models, including PM1, are part of this initiative. The other three models are listed as follows: Model 2 (PM2) Encounter-based to Value-based, Model 3 (PM3) Accountable Care Program and Multi-Purchaser, and Model 4 (PM4) Greater Washington Multi-Payer.¹⁵

There is strong evidence for collaborative care improving health outcomes for patients living with a mental illness. This includes evidence for depression, anxiety disorders, PTSD and co-morbid conditions such as heart disease, diabetes and cancer.¹⁶ Payment Model 1 goals include delivering coordinated, whole-person care to improve quality especially for individuals with physical and behavioral comorbidities. This aligns with the statewide goal for high quality care by 2019.

Behavioral Health Services Change

Behavioral health services have traditionally been delivered as two separate entities: mental health services and substance abuse services. However, a 2014 National Survey on Drug Use and Health report showed that over 18% of adults with mental illness suffer from a co-occurring substance use disorder.¹⁷ Data like these have given rise to policy change for

administering and paying for these services together. Healthier Washington initiated this change through the establishment of regional Behavioral Health Organizations (BHOs).

Other Washington regions will begin a similar Medicaid transition through coordinated but separate managed care contracts for physical and behavioral health. BHOs were created to replace Regional Support Networks (RSN) and to purchase and administer public mental health and substance use disorder services under managed care.¹⁸ The goal in some regions is to eventually transition BHO's to a Behavioral Health Administrative Services Organization (BH-ASO). The BH-ASO would deliver crisis services, administer non-Medicaid funding services, and manage regional functions as it does in Southwest Washington.¹⁹

Theory

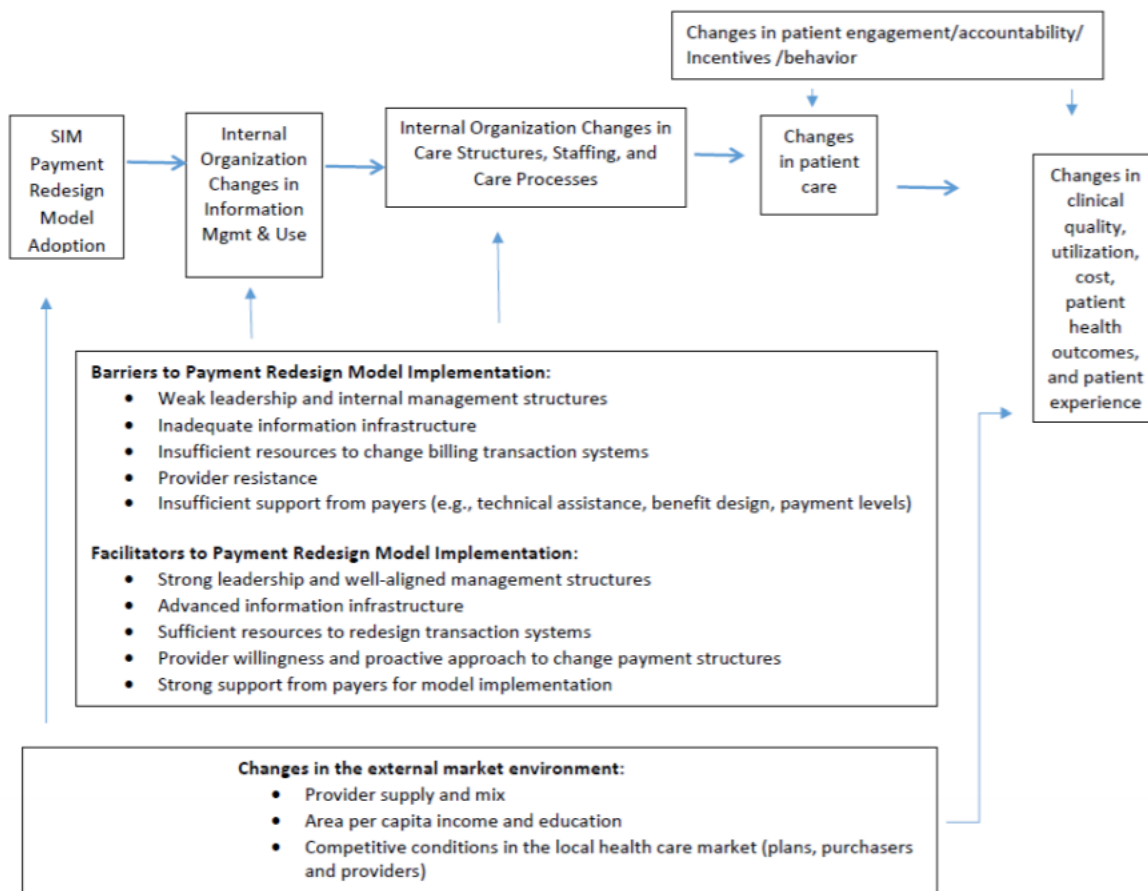
To ground the analysis, institutional and open systems theories in strategy formulation and management each explain the relationship of external environmental forces on organizational decision-making.²⁰⁻²² Resource Dependence Theory (RDT), a model that more narrowly focuses on managers' efforts to mitigate the influence of environmental forces, such as legislation, regulation, and competition, on organizational planning and operations balances the institutional and open systems theories through more intricate enumeration of external factors.^{20,22-24} A complementary model that emphasizes an organization's internal competencies and capabilities is the Resource Based View (RBV) of the firm. RBV emphasizes how an organization's tangible or intangible (internal) service delivery and support assets can influence antecedent conditions, which may promote or impede change. These assets may include individual competence, organizational structure, and/or financial resources.²⁵⁻²⁷ To create desired change, the organization must align and control its internal resources so as to exploit the environment, or simply mitigate its effects.^{22,28-32} Factors associated with open systems and

institutional theories generally, as well as those encompassed by RDT and RBV more specifically, inform the conceptual model included in this study.

Conceptual Framework

The analysis is informed by the conceptual framework presented here, derived from previous research by Conrad et. al.^{33, 34} This model describes the organizational steps towards payment redesign and adoption and how those in-turn lead to changes in information management use and internal care processes. These differences then inform variations in patient care, resulting in differences in quality, cost, patient health outcomes, and patient experience. Barriers, facilitators, and changes in the external market environment contribute to each of these intermediate steps, with direct and indirect impacts on overall healthcare outcomes. This framework guided the structured questionnaire and resulting analysis.

Figure 1. Conceptual Framework ^{33, 34}



Building directly on the ideas of change in the conceptual framework, the primary focus of this evaluation is to examine how payment reform has affected provider organizations in Southwest Washington involved in the early adoption of Medicaid integrated purchasing by asking the following: (a) What approaches did organizations employ to achieve the objectives of the payment model? (b) What results or progress has been observed? and (c) Which factors have helped or hindered implementation?

Methods

The Study Team and Research Approach

In collaboration with the Health Care Authority, the SIM PM1 evaluation aimed to enumerate the changes and conditions affecting payer and provider organizations in the Southwest Washington early adopter region. The goal of this work was to serve as a complement to the quantitative evaluation of the payment model conducted by the Department of Social and Health Services, Research and Data Analysis Division (RDA) over the same time-period (January 2017 to May 2018). The PM1 qualitative primary research team included three individuals: two research professors and one Public Health graduate student with continuous weekly contact with RDA and the Health Care Authority through the study period.

Study Design and Sample

Organizations were identified based on publicly available documents detailing involvement in Payment Model 1, as well as from collaborative work with the Health Care Authority. These documents were reviewed for background information and additional affiliations. The evaluation team developed organizational codes to protect each organization's privacy and differentiate roles in the payment model implementation: MCO1, MCO2, BHP1, BHP2, BHP3, BHP4, BHO1, PHC1. Table 1 delineates business models and service delivery for each participating organization. Organizations are further broken down into categories of health plans and consultant organizations vs. provider organizations for analysis.

Table 1. Organization Descriptors

Case	Organization (Abbreviation)	Description	Services Offered	Membership
1	Not-for-Profit, Washington-based, MCO (MCO1)	Managed Care Organization	Fully Integrated Managed Care	300,000 members in WA
2	For-Profit, Nation-Wide, MCO (MCO2)	Managed Care Organization	Fully Integrated Managed Care	663,000 Members as of February 2016 (WA) 631,000 Medicaid members
3	Not-for-Profit, Community Behavioral Health and Family Support Organization (BHP1)	Behavioral Health Provider Org.	Behavioral Health Support, Child and Family counseling, Family support, Adoption	30,000 children and families served in WA
4	Private, Not-for-Profit, Community Mental Health Center (BHP2)	Behavioral Health Provider Org.	MH, SUD, Housing Supportive Services	1700+ clients in Clark county.
5	Private, Managed Behavioral Health Organization (BHO1)	Behavioral Health and Administrative Services Organization	Crisis Services, Administrative services	Clark and Skamania counties in SW Washington.
6	Not-for-Profit, Medicaid-Focused, Behavioral Health Service Provider (BHP3)	Behavioral Health Provider Org.	Mental Health and SUD Services, Children and Family Services, Additional Community Services	Serves around 4,600 people per year in SW Washington
7	Private, Not-for-Profit, Behavioral Health Service Provider (BHP4)	Behavioral Health Provider Org.	SUD and Mental Health Services	Serve Approximately 3,000 people per year in SW Washington
8	Public Health and Community Services Entity (PHC1)	Local Health Jurisdiction	SUD Services, Children and Family Services	Serve all residents of designated county.

MCO1: A Non-profit Managed Care Organization founded in the early 1990's in Washington state. They currently serve over 300,000 members and in a provider network of 19 Community Health Centers with more than 130 Clinic's, more than 2,500 Primary Care Providers, 14,000 contracted specialists, and over 100 Hospitals, including 8 Western State hospital beds. The organization has been involved in mental health integration programs for approximately 10 years and includes an extensive network of Health Homes services.

MCO2: This For-profit MCO was started in the 1980's and came to Washington in the early 2000's. With 25 Western State hospital beds in Washington and a history of care integration, they serve approximately 663,000 Washington Members (as of February 2016) including 631,000 Medicaid, 10,000 Medicare (DSNP), and 22,000 Exchange members. This organization serves 37 of 39 counties in WA through government-based healthcare programs.

BHP1: A Non-profit community/behavioral health organization, they have served over 30,000 children and families in Washington. Their primary objective is to provide support for behavioral and physical health development for children in the welfare system. This includes child and family counseling with intensive services and wraparound services.

BHP2: A private, Non-profit licensed Community Mental Health Center established in the late 1990's, that currently serves over 1700 clients. This organization has a Mental Health care team of therapists, case managers, and peer support specialists and provides addiction support services and supportive housing services to WA residents.

BHO1: This Managed Behavioral Health Organization established in the 1980's serves more than 50 million people in the U.S. and U.K., has partnerships with 100 health plans, and maintains 7 Western State Hospital beds. As a behavioral health services provider, they provide a 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises, as well as extensive other services for treatment of mental health and substance use disorders.

BHP3: A Non-profit Established in 1942 in Washington, this organization provides Mental Health and SUD services, children and family services, additional community services. In 2016 they served 4,674 people, including 773 youth. They also house a 400-patient methadone clinic. Approximately 89 percent of organization funding is through Medicaid.

BHP4: This is a private, Non-profit corporation that has served the community since the 1960's, that became a certified Health Home Agency in 2016. This organization serves 3,000 people per year with a staff of board-certified psychiatrists and addictionologists, psychiatric nurse practitioners, mental health professionals, social workers, chemical dependency professionals, and registered and licensed practical nurses. This team provides SUD and Mental Health Services to Washington residents with 90% of funding coming from public sources.

PHC1: This informant is a public health entity that aims to provide a variety of services to residents of a county. Services include substances use services but are wide in breadth. They are not considered a direct services provider.

Data Collection

The PM1 investigative team, composed of the principal investigator, lead qualitative investigator, and research assistant, conducted eight key informant interviews with twelve healthcare executives representing organizations administering healthcare in the Early Adopter Region of Southwest Washington for Payment Model 1 of the SIM initiative. The lead qualitative investigator contacted key informants via email through purposeful sampling between June and October 2017.³⁵ Informants (n=12) from the eight organizations participated in a combination of two face-to-face and six telephonic interviews. Semi-structured interviews with each of the respondents were conducted using a single questionnaire aligned with the conceptual framework, which lasted 37 to 70 minutes each.^{33,34,36} Both clinical and administrative points of view were represented throughout the interviews as determined by the informants' training, with three interviews representing clinical backgrounds and five representing administrative backgrounds. All interviews were recorded, transcribed, and de-identified. Notes and transcripts were transcribed and subjected to two rounds of coding using Dedoose©(v8.0.42) qualitative coding software for analysis. To obtain thematic results by interview question, an abductive approach (used a framework and grounded theory. Framework is top-down and grounded is bottom up) was used. The team first coded questions using the interview framework as a guide, then secondarily employed the axial coding component of grounded theory by building core themes through the process of relating codes.^{37,38} Thematic codes were developed based on the conceptual framework and research questions to describe the general categories of responses. To triangulate results, investigators reviewed thematic findings independently, addressed discrepancies, and clarified results with the larger evaluation team.^{35,39}

Results

Table 3 details the emergent themes of the eight Key Informant Interviews. Organized by interview question and in alignment with the conceptual model, results of the qualitative analysis are first divided into 12 topic domains: Goals for Organizations, Expected Benefits of PM1, Reason for Participation, Expected Effect of PM1 on Population Health, Expected Effect of PM1 on Quality of Care, Expected Effect of PM1 on Patient Experience, Expected Effect of PM1 on Cost of Care, Organizational Objectives related to PM1, Organizational Approach, Chain of Events, Facilitators and Barriers, and Sustainability. Next, each topic is broken down thematically and assessed to determine either positive, negative, or neutral progress towards overall integration efforts. Positive indicates both expressed optimism of the efforts and general growth, Neutral indicates an expression of apathy or stagnation in integration, and Negative indicating expressed pessimism or impediments towards a goal for integration. Behavioral health providers are distinguished from all other organizations interviewed in the last two columns. This distinction is important for understanding how the integration of financing directly affects patient care, outcomes, and experience by separating informants involved in direct service delivery.

Table 3. Emergent Themes and Illustrative Quotes

<i>Question Topic</i>	<i>Emergent Theme</i>	<i>Positive, Neutral, or Negative Progress</i>	<i>Health Plans and Consultant Orgs.</i>	<i>Provider Orgs.</i>
Goals for Organizations	Changes in Service Delivery	Positive	“priorities of seeing cross system coordination. Crisis services, falls into behavioral health services but also crosses over to law enforcement, medical providers, school systems for kids and of course families’ natural supports as well. So we would really like to see more system integration again tied to the goals around continuum care...” (BHO1)	“Ultimately looking at making adjustments to the way we deliver care, and that would be the way we delivered healthcare but also the where we deliver it, who we partner with, all those discussions because we revolve around integration of care.” (BHP4)
	Quality Improvement	Positive	“achieving higher HEDIS results” (MCO2)	stating a need to “look for ways to strengthen our existing programs, both clinically and financially”. (BHP4)
Expected Benefits of PM1	Care Integration	Positive	“We are [re]moving the silos and integrating the financing, we will support paying for care in a way that supports delivering care in an integrated way.” (MCO2)	“I think what you will see is Medicaid covered life in the region will go in somewhere and they will say, hey, this is me and they won’t have to go walk out and go look for SUD treatment somewhere else as a separate effort. They won’t have to go and look for primary care and mental health at a separate effort. That will be the single door access point...” (BHP2)
	Improved Health Outcomes	Positive	“...if the funding is siloed, there is not that incentive to invest dollars in another system. So, by aligning the financial incentives you facilitate investment into total care that get better outcomes.” (MCO2)	“that providing good healthcare services to children and families has a disproportionately positive impact on the population as a whole” and “we really do see the potential to positively impact society thirty years from now and not just in saving a few bucks this year.” (BHP1)

Reason for Participation	External Pressure	Neutral	<i>No examples were mentioned for these organizations</i>	“I didn’t have a choice to participate and that is not a grievance. Our County Counselors voted to do this, to be early adaptors, so it wasn’t a decision on the providers part, it was the County decision, County legislative decision.” (BHP2)
	Belief in the Model	Positive	“So, we have that experience of having an integrated funding stream for both physical and behavioral health for that population and because of those benefits it seems that, so when there was opportunity to do that for the [Medicaid] population as a whole. So huge opportunity. We also had a number of outcomes demonstrated from our experience with them including improvement in depression score, reduction in ER, reduction in inpatient.” (MCO1)	“So, for us it was the unknown was better than the known and that was probably the biggest driving aspect to it, getting to a high ground then the goal of actually seeing our clients receive better care, which is obviously something we are always looking towards.” (BHP3)
Expected Effect of PM1 on Population Health	Time-dependent	Positive	“If you move to sub-populations like individuals with chronic mental illness and their health conditions I think we will have an impact on that but that will take time...I don’t think you will see that in the first year but we do have the anecdotal reports from our behavioral health providers who say they feel like their patients are getting better access to primary care by working with us and working within an integrated model.” (MCO2)	“the financial integration has happened the deal that, it intended to happen April 1, 2016 and it has really gotten and continued the way it should happen about six months after that. Clinical integration is a whole other dynamic and that will take many years to integrate systems clinically. So that being said, I think <i>eventually</i> population health and these other items will be addressed” (BHP4)
Expected Effect of PM1 on Quality of Care	Co-morbidity Management and Coordination	Positive	“...it was like somebody had flipped a switch...and suddenly our ability to coordinate care for complex members with both chronic medical and behavioral health conditions changed	“...if we are clearly providing integrated care that does take time and we are working through that as a region now, truly integrated care improves quality of care when you have primary care

			significantly. So, to sum it all up I would say for in the complex individuals with complex chronic conditions, medical and behavioral health conditions, we are much more able to effectively coordinate care.” (MCO2)	physicians and specialist physicians and behavioral health clinicians, all communicating around somebody’s health. I’d venture to say 99% of the time, it is not all the time, the outcomes are typically better.” (BHP4)
Expected Effect of PM1 on Patient Experience	Mixed Sense of Change	Neutral	<p>“I would think that ultimately all of this is to impact the patient experience and improve their experience. I think you can talk about the big picture, talk about money but ultimately what we are trying to do is improve that experience in their care. So, I sure hope so.” (BHO1)</p> <p>and</p> <p>“I’m hopeful that if we address the social determinants also that would improve the patient experience but if there is problems with access and we don’t have enough primary care providers...I think that can have a detrimental, I mean, it wouldn’t be anything worse than what we’ve experienced in the past. Theoretically the patient experience should improve” (PHC1)</p>	<p>“...you will hopefully simply things and you don’t have a bifurcated system, it becomes less confusing and that I think has a direct benefit on patient satisfaction and they can access care easier, when it’s a little easier for them to understand that improves satisfaction.” (BHP4)</p> <p>and</p> <p>“I think that – I don’t think a patient would necessarily tell you this, some of them might, they experience a fragmented care system.” (BHP2)</p>
Expected Effect of PM1 on Cost of Care	Time-Dependent	Neutral	<p>“...there is still some lag time in terms of cost savings that we are seeing. So, we can’t at this moment say we are seeing millions and millions of dollars...I think that’s a lot more difficult to quantify the impact of the whole system. So are we seeing reduction in arrest rates that would then have cost implications for the criminal justice system or housing systems too.” (MCO1)</p>	<p>“I think when you have the managed care organizations really focusing on trying to bend that cost curve by providing better interventions and better monitoring of their members and working with providers on providing wrap-around services when needed, health homes, care coordination is big. They are kind of doing that. I think that is going to</p>

				eventually sort of bend that cost curve and build high quality care for less cost.” (BHP4)
Organizational Objectives related to PM1	Triple-Aim Related Goals	Positive	“I think it enables us to achieve the triple aim...the opportunity to leverage best practices from the behavioral health world as well as from the physical health world” (MCO1)	“...the care integration piece that you will be able to at least bend the cost curve overwhelmingly in primary care” (BHP3)
	Organizational Development	Positive	<i>No examples were mentioned for these organizations</i>	“That comes down to exploring partnerships, exploring partnerships-local physical care providers with local primary care doctors, strengthening those relationships, talking about new ways we can complement each other” (BHP4)
	Reform Expectations	Neutral	“I don’t think...the financial integration alone is going to help us achieve those outcomes. It’s also going to take that delivery system reform on the ground with the people delivering the care directly in order to really achieve those objectives” (MCO1)	“...more realistic to see in a year, at the end of year two, at the end of year three. And I think I’m optimistic some of that stuff could happen” (BHP2)
Organizational Approach	Training	Neutral	“There is a big piece just around getting together with providers to assess sort of what were their immediate needs and so Southwest Washington...doing that initial survey to get a sense of where were those pain points and with Southwest Washington...So based on what we were hearing from them, we worked with our partners...to develop some training and resource around that, so that we could serve -- kind of advancing the least comfort level and you know managing those aspects of the population.” (MCO1)	“...we got a lot of technical consultation leading up to it so we attended webinars from various national experts on transition to managed care, how to prepare your agency for that, what kind of things you need to do, consider, all that sort of stuff and we probably had, I don’t know, I know we only just had ten webinar series, it is like three hour webinars, they are driving this and various people who pulled in were experts in their area.” (BHP2)

	Provider Hesitation	Negative	“there is a level of resistance from the provider community especially on the mental health side to do things differently. So, while we want to promote financial and clinical integration, it needs to be knowledge that takes time and providers are concerned about losing patients, losing work, losing money in that process. It needs to be acknowledged.” (MCO1)	“I have heard some concern from providers that as the HCA moves to value-based contracting with MCOs... There is concern but functionally that will be the reality on the ground for providers and I don’t know if that will or won’t be the case but that would be really disappointing. My sense is that’s not the intention in the exercise at all. There is some trepidation over that sort of thing.” (BHP1)
	Analysis of Payment Mechanisms		<i>No examples were mentioned for these organizations</i>	“I think we have been so consumed by the sort of the basic needs getting paid, figuring out why we were not getting paid, adjusting our systems so that we can fix these problems so that they are not ongoing problems, so that consumed so much of our bandwidth...” (BHP2)
Chain of Events	Steps Toward Care Integration	Positive	“So, I think that first of all, it goes from the top all the way down to the bottom and promote mission and vision that support integrated care and then operationalizing that because integrated care impact every aspect of the organization operation... We have talked about FIMC not being a program to us, it’s a <u>new culture</u> , it’s a new way” (MCO1)	“I think everyone wants to integrate the care, I think most folks do. It is just getting the systems in place to do so. I think the first always is identifying partners, identifying organizations that have like missions and like objectives” (BHP4)
	Internal Resources – Workforce Changes	Neutral	“So there has been a lot of education internally of existing staff and then sort of targeted hiring to bring some of that expertise in house as well.” (MCO1)	“Well, the workforce training with workforce resources of some sort would definitely be a huge benefit.” (BHP3)
	Internal Resources – Data Management	Positive	“Well, off the top of my head I think the primary resources are data and premium. So now we have the data to actually report behavioral health measures	“I do think that sharing data on some level... I do think that is the type of thing that will help realize the things that we talked

			and we have...a total care premium to work with, to cover those services.” (MCO2)	about before: better coordination, more timely care, reduced costs” (BHP1)
Facilitators and Barriers	Workforce Barriers	Negative	<i>No examples were mentioned for these organizations</i>	“We have a real difficult time both recruiting and retaining quality staff, predominantly because of pay.” (BHP3)
	Regional Leadership Barriers	Negative	“I think the biggest challenge that providers are facing right now is that there is no clear leadership around who is charging the integration forward. I think that’s a point of frustration for them actually, and I think there is a little bit of lack of clarity between the roles of the health plan, the roles of ACH, the accountable community of health and the role of the transformation hub. So, I think it feels confusing at times and has been the experience of like nothing happening.” (BHO1)	“Our biggest barrier right now is the lack of knowledge for what is going on. It sounds to me like the ACH, the HCA, the MCOs are all talking with each other about value-based payments...but all we get is a little snippets and rumors about these conversations we are not involved in. And so, we have a huge lack of information to be able to weigh in on and know what the future is going to look like.” (BHP3)
	Organizations as External Facilitators	Positive	“...the other facilitator would be close working relationship between...healthcare authority and DOH as well as relationships at the local level. You know, figuring out how state government works both within HCA as well as between HCA and DOH should be really helpful” (PHC1)	“Well, the facilitators are like obviously, the accountable community of health, the county has been a great facilitator, health care authority and the managed care plans, we have a local behavioral health alliance” (BHP4)
	Financial Facilitators	Neutral	“They have \$16 million from CMMI to hire practice coaches and to give money to practices to make some practice changes. That resource coupled with expertise is helping practices get engaged, without a dollar to help with the transformation it wouldn’t be working” (MCO2)	“I have probably the best hope right now in the ACH that – as it gets going and some of that demonstration money becomes available to help with this...” (BHP3)
Sustainability	Sustainability in Funding	Neutral	“Sticking to the discipline of our business model	“Well, I hope that that there is funding from the

			through all these changes” and “Advocate for an actuarially sound premium.” (MCO2)	managed care organizations that is kind of since they are the holder of all the funds, the sustainability will rest on what they are going to fund and how they are going to fund it. So as a provider sustainability only goes so far. It is who’s going to pay me to do something and how are they going to pay me.” (BHP4)
	Sustainability in Care	Neutral	“We need to advance clinical integration and based on that we expect to see improved outcomes for our members and also reduction in unnecessary utilization which will result in cost savings which can then be further reinvested in the delivery system.” (MCO1)	<i>No examples were mentioned for these organizations</i>

Organizational Goals

Six informants - BHP4, BHP3, BHO1, BHP2, MCO1, BHP1 - mentioned over-arching goals of changing service delivery and improving quality of care for their patients. Primary emphasis centered around changes in service delivery models which includes but is not limited to: co-location of services, promoting a continuum of care throughout the behavioral health system, integrating care, and changing to a holistic service model. A secondary emphasis for informants was on quality improvements at the organizational level. Strengthening existing programs, improving reporting and documentation practices through EHRs or other means, and achieving performance related goals such as HEDIS measures or health equity measures were examples given for quality improvement changes.

Expected Benefits

These answers reflect a wide range of impacts; from benefits to general population health to changes in specific standards of care within the informant's organization. Five of the informants (MCO1, MCO2, BHP2, BHP4, BHO1) mentioned PM1 leading to care integration as an expected benefit. This stemmed from the idea of providing Whole Person Care and removing the siloes that Behavioral and Physical Health are often partitioned into. A secondary probe asked how PM1 goals aligned were aligned with the informants' organizational goals. Answers included the following: care coordination, reducing ED use, and one-stop-shopping. These reflect the trend toward of eventual full care integration within the organization.

Effects on Population Health, Quality of Health Care, Patient Experience, and Per Capita Cost

Expected effectiveness was generally uncertain for Population Health and Cost of Care with all informants expressing some hesitation in predicting effects and noting that any observable effects would take time. Informants were more opinionated on the effects of PM1 on Patient Experience, being either very pessimistic or very optimistic with both sentiments expressed by both the providers and the health plans. One informant, BHP3, cited that there were no observable effects from PM1 and that everything was business as usual. A congruent idea offered by PHC1, was the notion that integration was necessary, but not sufficient to improve population health and that other social determinants would first needs to be addressed. Responses to improvements quality of care were mixed - ranging from a simple "not as a direct result", to sentiments that quality of care would not be affected without other interventions. Two informants, BHP2 and PHC1, mentioned that integration with social determinants would be necessary to achieve true quality. While an informant from BHP1 mentioned that the behavioral

health system is traditionally not a good business model for delivering quality due to funding and staffing concerns.

Expected Objectives

All but one respondent mentioned patient-centered objectives as expected results of PM1. This included responses on care coordination, care integration, and a desire to achieve the Triple Aim. Organizational development objectives were frequently mentioned as an expectation for PM1. This included increasing communications between or within organizations and achieving funding support to continue the payment model reform activities as well as strengthening existing partnerships in the region.

Organization's approaches for attaining PM1 objectives

Two informants from provider organizations, BHP3 and BHP2, mentioned that they were left to do a lot of the work and prep for PM1 themselves. Trainings were provided for the region, but internally, reorganization was left up to the individuals. In addition, BHP1 cited a primary objective of enhancing the ability to track outcomes because there is no silver bullet for measuring impact yet in behavioral health. Electronic health records were mentioned as tools for payment model preparation by providers, but there was skepticism about how the data could be used to improve health outcomes. In addition, providers expressed hesitation concerning the new payment mechanisms due to the transition to value-based payments and the traditional underfunding of behavioral health.

Chain-of-Events

The most common response when asked about processes and chain of events leading to PM1 objectives was a general trend toward service and care integration. This was expressed by both MCO's and three behavioral health provider organizations showing that integration for care

and services is not isolated to only payers or only providers. One informant from an MCO viewed this payment model integration as not just a chance to change their service delivery model, but as a culture change for the entire organization. Two informants also emphasized the need for strong partnerships in the region to realize the objectives of PM1. Relationships and leadership were the two over-arching themes that stood out when informants were asked about external resources leading to the expected changes from PM1. Workforce changes such as adding community health workers to staff and increasing primary care provider networks were mentioned by BHP3, MCO1, BHO1, and PHC1 as necessary internal resources to realize the expected changes from PM1.

Major Facilitators and Major Barriers

Specific organizations were cited as facilitators to achieving PM1 objectives. County leadership, the Healthcare Authority, the Accountable Community of Health (ACH), and the Managed Care Plans were all mentioned multiple times as facilitators with informants citing the support and check-ins from these entities as most helpful. Two clinical informants from behavioral health organizations mentioned workforce issues as a barrier to integration. One Community Mental Health Clinic in the region, BHP2, noted that recruiting all levels of providers as well as workforce retention has been an ongoing challenge, citing a lack of funding. Regional agreement issues, stemming from a lack of direction or clear leadership, were mentioned in multiple interview questions. This recurring theme pervaded the informant interviews but showed up predominantly when asked directly about barriers.

Plans for Sustaining PM1

When asked about sustainability, most informants were brief, but provided helpful examples for the future. Plans for PM1 sustainability by MCOs included advancing clinical

integration, increasing flexibility for providers, and adhering to a strict business model. Plans for PM1 sustainability by BH providers included finding new funding, maintaining existing funding, as well as an expressed fear of losing funding by multiple organizations. These responses echo the need for funding support throughout the region to maintain integration efforts.

Discussion

This study expands the framework by Conrad et.al (2009, 2014) on the effects of payment reform on provider organizations and patient outcomes through original empirical grounding of the framework. The emergent themes typify the nature of the changes in Southwest Washington and explore the effect and expected effects of reform on these organizations. SIM transformation efforts across the country can adapt and add to the knowledge of this existing framework.

What approaches did organizations employ to achieve the objectives of the payment model?

This study first asks about what strategies and theories organizations employed to achieve the objectives of the payment model. Responses included extensive trainings, analysis of payment mechanisms, workforce changes, and data management strategies, which were all employed to ready these organization for payment reform in the region. However, behavioral health providers noted that much of the organizational restructuring and adapting for the payment model was completely internal and unguided. There were mixed feelings towards this approach as providers expressed an appreciation for the flexibility of the requirements by the MCOs compared to previous health plans in the region but questioned whether their organization was truly prepared for the payment reform.

What results or progress has been observed?

Overall, respondents mentioned a general trend toward service and care integration. This was expressed by both MCO's and behavioral health providers showing that the goal of full integration for care and services is not unique to one type of participating organization. One informant from an MCO viewed this payment model integration as not just a chance to change their service delivery model, but as a culture change for the entire organization. The concept of time or a time-dependence pervaded multiple responses with all organizations expressing some level of hesitation to enumerate concrete or tangible progress. Some organizations felt that payment integration would simply not be enough to drive service delivery changes in the region, while others expected apparent results in five to ten years.

Which factors have helped or hindered implementation?

Providers cited the guidance of local entities as both a help and a hindrance in this work noting that collaborating with individual leaders in the region was helpful, but the sheer amount of regional leadership caused some confusion concerning the future of the payment model. The most concerning barrier to implementation mentioned was a lack of clear leadership or agreement throughout the region, as the extensive involvement of multiple organizations such as the Department of Health, HCA, the ACH, and other county leadership led to a lack of guidance on who should be consulted in the continuation of the model. Other initiatives in the region such as the ACH, may have blurred the lines between this SIM payment transformation and other portions of the co-occurring Healthier Washington Initiative. However, it is worth noting that although organizations were confused about who was leading the region, they did count on the

multiple leading entities to guide them through trainings and assist with questions in the rollout of the model and appear satisfied with the help they received.

Overall, the transformation efforts showed positive progress in most topics queried in the Key Informant Interviews. Although there are places for improvement, the Early Adopter region shows promise for the rollout of physical and behavioral health integrated purchasing throughout the state through 2020.

Limitations

Like all qualitative research, some level of inherent value-judgment exists in the analysis of the results. Although this limits our ability to determine causality within observed relationships, as they are reflections of participating organizations in a single regional setting, parallel evaluations are being conducted in multiple states and at the federal level. Therefore, potentially validating the methods and approach for this theme analysis. In addition, previous works show that early evaluations of payment models bear fruit for future policy changes.

Practice Implications

Implications for policy and practice from this study extend to the sustainability of SIM transformation efforts and future payment integration efforts. First, the sustainability of SIM effort will clearly be funding-dependent, indicating an unclear future after CMMI funding ends for the initiative. Bolstering communication with regional leadership and defining clear regional goals, will be important for decreasing provider hesitation and engaging providers in the process of practice transformation. Future payment integration efforts should heed lessons from this early adopter by analyzing the distribution of Medicaid contracts, consulting providers at all levels of primary and behavioral health care, and ensuring clear paths for the direction of service integration.

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