INTEGRATING PRIMARY CARE and BEHAVIORAL HEALTH CARE

NAMD November, 2014
Missouri Medicaid Overview

- 890,000 covered lives and $8 Billion annually
- No expansion so far
- TANF and CHIPS
  - 398,000 in Managed Care
  - 216,000 in FFS
- ABD and others all in FFS
- Pharmacy and LTC in FFS
What is a Health Home?

- Not just a Medicaid Benefit
- Not just a Program or a Team
- A System and Organizational Transformation
Health Home
Target Populations

- Patients with Diabetes
  - At risk for cardiovascular disease and a BMI > 25

- Patients who have two of the following
  - COPD/Asthma
  - Diabetes (also as single condition)
  - Cardiovascular Disease
  - BMI > 25
  - Developmental Disabilities
  - Use Tobacco

- Individuals with a serious mental illness; or with other behavioral health problems who also have
  - Diabetes
  - COPD/Asthma
  - Cardiovascular Disease
  - BMI > 25
  - Developmental Disabilities
  - Use Tobacco

Primary Care Health Homes

CMHC Healthcare Homes
Missouri’s Health Homes

**Primary Care Health Homes**

- **Providers**
  - 18 FQHCs
  - 67 Clinics
  - 6 Hospitals
  - 22 Clinics
  - 14 Rural Health Clinics

- **Enrollment**
  - 14,981 total

**CMHC Healthcare Homes**

- **Providers**
  - 28 CMHCs
  - 120 Clinics/Outreach Offices

- **Enrollment**
  - 19,780 total
Health Home Team

- Nurse Care Managers (1FTE/250pts)
- Care Coordinators (1FTE/500pts)
- Health Home Director
- Behavioral Health Consultants (primary care)
- Primary Care Physician Consultant (behavioral health)
- Learning Collaborative training
- Next day notification of Hospital Admissions and ER visits
Bi-Directional Integration

Primary Care Health Homes

- Behavioral Health Consultants
- SBIRT (web-based)
- PHQ 2 screening
- 6 of 20 Quality Performance Measures are BH
- 4 of 8 Medication adherence measures are BH
- BH prescribing benchmarking and feedback

CMHC Healthcare Homes

- Primary Care Consultants
- Primary Care Nurse Care Managers
- Annual+ Metabolic Screening
- Diabetes Education
- 10 of 20 Quality Performance Measures are Medical
- 4 of 8 Medication adherence measures are medical
BLOOD PRESSURE Changes Over Time

6 POINT DROP IN BLOOD PRESSURE!

- **16% ↓** in cardiovascular disease
- **42% ↓** in stroke

**CMHC-HHs**

Baseline: 144.75 mm Hg
Year 1: 133.35 mm Hg
Year 2: 131.50 mm Hg

Systolic: -13.25 mm Hg
Diastolic: -8 mm Hg

**PCHHs**

Baseline: 149.38 mm Hg
Year 1: 142.40 mm Hg
Year 2: 143.87 mm Hg

Systolic: -5.51 mm Hg
Diastolic: -4.82 mm Hg

6 POINT DROP IN BLOOD PRESSURE!

- **16% ↓** in cardiovascular disease
- **42% ↓** in stroke
LDL Levels Over Time

10% DROP IN LDL LEVEL!

- 30% ↓ in cardiovascular disease

CMHC-HHs

Baseline: 130.25
Year 1: 115
Year 2: 111.5

PCHHs

Baseline: 130.28
Year 1: 121.53
Year 2: 117.19
A1C Levels Over Time

1 POINT DROP IN A1C

- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications

CMHC-HHs

Baseline | Year 1 | Year 2
---|---|---
10.01 | 8.96 | 8.58

PCHHs

Baseline | Year 1 | Year 2
---|---|---
9.81 | 9.20 | 9.07
Outcomes
Reducing Hospitalization

% of Patients with at least 1 Hospitalization

Primary Care Health Homes

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>23.9</td>
</tr>
<tr>
<td>2012</td>
<td>15.7</td>
</tr>
</tbody>
</table>

CMHC Healthcare Homes

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>33.7</td>
</tr>
<tr>
<td>2012</td>
<td>24.6</td>
</tr>
</tbody>
</table>
Initial Estimated Cost Savings after 18 Months

- **PC Health Homes**
  - 23,354 persons total served (includes Dual Eligibles)
  - Cost Decreased by $30.79 PMPM
  - Total Cost Reduction $7.4 M

- **CMHC Health Homes**
  - 20,031 persons total served (includes Dual Eligibles)
  - Cost Decreased by $76.33 PMPM
  - Total Cost Reduction $15.7 M
FQHC/CMHC Integration Initiative

- Ongoing since 2008
- Seven PC/BH ongoing partnerships ($200K) funded
  - BH services on-site at PC clinic by CMHC
  - PC services on-site at CMHC by PC clinic
- Six additional sites received one-time funding for planning per partnership ($30K)
- Jointly staffed by:
  - Medicaid
  - Dept MH
  - MO Primary Care Association
  - MO Coalition of CMHCs
Use Multiple Models

- Traditional MH services at FQHC by CMHC
  - Brief Therapy
  - Psychiatric Evaluation and Med Management
- New Approaches at FQHC
  - SBIRT
  - Embedded BH Consultant on PC team
- Traditional PC services at CMHC by FQHC
More Organizations are both CMHC and PC
- Five CMHCs obtained new FQHC status
- One merger of a CMHC with a FQHC
- One CMHC acquired a RHC

More FQHCs have chosen to contract with CMHCs for BH services at other sites beyond the grant rather than develop their own BH services

Funding using FQHC method through MPCA leverages funding for uninsured by 30%
Integration via Managed Care

- MC plans required to comply with Wellstone-Domenici Mental Health Parity statute and CMS regulations for commercial plans
- MC plans required to contract with CMHCs as essential providers
- MC plans required to use LOCUS/CALOCUS LOC criteria for authorization of BH services
- Joint DMH/Medicaid review of MC plan case management in BH
- Substantial DMH input of MC RFP and contracts
Pro-Integration Policies

- FQHCs are paid for both PC and BH visits on the same day
- BH organizations allowed to bill for PC services and PC organizations allowed to bill for BH
- SBIRT and HBAI codes covered
- DMH has ongoing and substantial input on Medicaid FFS Pharmacy and psychotherapy PA committees
- Cross Hiring
Data Sharing

- Extensive data exchange between DMH and Medicaid
- Mental PHI shared same Medical PHI per HIPAA
  - Medicaid centric claims based EHR available to all providers
  - Medicaid claims information available as CCD on state HIE
- 42 CFR part 2 construed as narrowly as possible
LIMITATIONS

Until you spread your wings,
You'll have no idea how far you can walk.