PAYMENT INNOVATIONS SUPPORTING BEHAVIORAL HEALTHCARE DELIVERY IMPROVEMENT

NGA

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My Background

• Medicaid Director
• Previously DMH Medical Director – 20 years
  – Practicing Psychiatrist
  – CMHCs – 10 years
  – FQHC – 18 years
• Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
• Adjunct Professor of Psychiatry – University of Missouri Columbia
MISSOURI’S CMHC/FQHC INTEGRATION PROJECT

PAYMENT INNOVATION = BUYING A RELATIONSHIP
FQHC/CMHC Integration Initiative

- **Expectations**
  - Co-location of primary and behavioral health services
  - Appropriate adoption of evidenced based practices, best practices, and promising practices
  - Receptivity to person centered planning, and consumer empowerment
  - Appropriate incorporation of existing care management technologies and initiatives

- **Design**
  - Seven partnerships funded for three years
  - Six additional sites received one-time funding for planning per partnership
  - Technical Assistance Team (supported by a grant from the Missouri Foundation for Health)
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
Progress to Date

- More Organizations are both CMHC and FQHC
  - Six CMHCs obtained new FQHC status
  - two mergers of a CMHC with a FQHC

- 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%
DM 3700

HOT SPOT OUT REACH TO HIGH UTILIZERS

Payment Innovation = Payer Chooses the Patients and Performance Bonus
Change in Business

- **old model**
  - Client, family, or healthcare referral makes a call if the consumer seeks services, and they have to be evaluated for eligibility to receive services.

- **New Model**
  - High cost, high risk outreach to selected consumers that the payer has selected for services.
Old
NEW
Target Population

- $20,000 minimum cost for previous 12 months or risk predicted to have high cost
- A diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or recurrent major depression
- Not a consumer of public mental health system in previous 12 months
- Excluded nursing home, developmental disability, hospice and renal failure
- Average cost of group over $50,000 per year
Chronic Disease

Percent of Continuous HCH Enrollees with Chronic Diseases
June 2013

- Diabetes: 35% (DM 3700), 30% (All HCH Adults), 8% (Gen. Adult Pop.)
- Asthma/COPD: 27% (DM 3700), 25% (All HCH Adults), 15% (Gen. Adult Pop.)
- CV Disease: 8% (DM 3700), 4% (All HCH Adults), 4% (Gen. Adult Pop.)
- Hypertension: 47% (DM 3700), 40% (All HCH Adults), 30% (Gen. Adult Pop.)
Diabetes Control

Percent of Continuously Enrolled DM 3700 HCH Adults with Diabetes with LDL, BP, and A1c in Control

- **Diabetes LDL**: Feb-12 (19%), Jan-13 (34%), Jun-13 (41%), Goal (47%)
- **Diabetes BP**: Feb-12 (25%), Jan-13 (41%), Jun-13 (53%), Goal (59%)
- **Diabetes A1c**: Feb-12 (15%), Jan-13 (31%), Jun-13 (43%), Goal (53%)
Hypertension Control

Percent of Continuously Enrolled DM 3700 HCH Adults with Hypertension With Blood Pressure in Control

Feb. 2012: 24%
Jan. 2013: 36%
Jun. 2013: 47%
Goal: 60%
All HCH Adults: 55%
Cardiovascular Disease Control

Percent of Continuously Enrolled DM 3700 HCH Adults with Cardiovascular Disease with LDL in Control

- Feb. 2012: 21%
- Jan. 2013: 33%
- Jun. 2013: 43%
- Goal: 70%
- All HCH Adults: 49%
Initial Estimated Cost Savings after 18 Months

- **Health Homes**
  - 43,385 persons total served (includes Dual Eligibles)
  - Cost Decreased by $51.75 PMPM
  - Total Cost Reduction $23.1M

- **DM3700**
  - 3560 persons total served (includes Dual Eligibles)
  - Cost Decreased by $614.80 PMPM
  - Total Cost Reduction $22.3M
What is a Health Home?

- Not just a Medicaid benefit
- Not just a program or a team
- A system and organizational transformation
Population-Based Payments

• Payments for HH services will be paid PMPM, not unit by unit

• Patients will be identified by health service history and current health status

• Outcomes will be measured by groups of clients (i.e., by organization, region, medication used, co-morbid conditions)
Six CMS Required Health Home Services

- Care Management
- Care Coordination
- Referral to Community Services
- Managing Transitions of Care
- Individual and Family Support
- Health Promotion
Health Home Strategy

- Integrated primary care and behavioral healthcare
- Case management coordination and facilitation of healthcare
- Primary Care Nurse Care Managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
- Preventive healthcare screening and monitoring by MH providers
- Behavioral health management and behavior modification as related to chronic disease management for persons with medical illness
Health Home Strategy

Health technology is utilized to support the service system.

“Care Coordination” is best provided by a local community-based provider.

MH Community Support Workers: Workers who are most familiar with the consumer provide care coordination at the local level.

Statewide coordination and training support the network of Health Homes.

Primary Care Nurse Care Managers: Working within each Health Home provide system support.

Behavioral Health Consultants: In each Primary Care Health Home.
Missouri’s Health Homes

Primary Care Health Homes

• Providers
  – 18 FQHCs
    ■ 67 Clinics
  – 6 Hospitals
    ■ 22 Clinics
    ■ 14 Rural Health Clinics

• Enrollment
  – 15,526 adults
  – 428 children
  – 15,954 total

CMHC Healthcare Homes

• Providers
  – 28 CMHCs
    ■ 120 Clinics/Outreach Offices

• Enrollment
  – 16,611 adults
  – 2,387 children
  – 18,998 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
# Bi-Directional Integration

<table>
<thead>
<tr>
<th>Primary Care Health Homes</th>
<th>CMHC Healthcare Homes</th>
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<tbody>
<tr>
<td>Behavioral Health Consultants</td>
<td>Primary Care Consultants</td>
</tr>
<tr>
<td>SBIRT (web-based)</td>
<td>Primary Care Nurse Care Managers</td>
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<tr>
<td>PHQ 2 screening</td>
<td>Annual+ Metabolic Screening</td>
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<tr>
<td>6 of 20 Quality Performance Measures are BH</td>
<td>Diabetes Education</td>
</tr>
<tr>
<td>4 of 8 Medication adherence measures are BH</td>
<td>10 of 20 Quality Performance Measures are Medical</td>
</tr>
<tr>
<td>BH prescribing benchmarking and feedback</td>
<td>4 of 8 Medication adherence measures are medical</td>
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CMHC Health Home Performance Progress

LDL, A1C, and Blood Pressure
Outcomes | Metabolic Syndrome Screening

Metabolic Syndrome Screening (All HCH Enrollees)

Feb'12 Baseline
Feb'13 12 Months
June'13 18 Months
Jan'14 2 Years
June'14 2.5 Years
March '15 3 Years

12% → 46% → 61% → 80% → 80% → 86%

74%
Outcomes | LDL Levels

- 10% ↓ in LDL level
- 30% ↓ in CD
Outcomes | A1C Levels

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<thead>
<tr>
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<th>CMHCs</th>
<th>PCHHS</th>
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<tbody>
<tr>
<td>Baseline</td>
<td>10.01%</td>
<td>9.81%</td>
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<tr>
<td>Year 1</td>
<td>8.96%</td>
<td>9.20%</td>
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<tr>
<td>Year 2</td>
<td>8.58%</td>
<td>9.07%</td>
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1 point drop in A1c
- 21% ↓ in diabetes-related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications
Outcomes | Hypertension and Cardio

Good Cholesterol for Clients w/ CVD (<100 mg/dL)

- Feb'12: 21%
- Feb'13: 37%
- June'13: 49%
- Jan'14: 55%
- June'14: 55%

Normal Blood Pressure for Clients w/ HTN (<140/90 mmHg)

- Feb'12: 24%
- Feb'13: 41%
- June'13: 55%
- Jan'14: 62%
- June'14: 65%
Outcomes | Diabetes

- **Good Cholesterol (<100 mg/dL)**: 22% (Feb'12), 38% (Feb'13), 47% (June'13), 50% (Jan'14), 59% (June'14)
- **Normal Blood Pressure (<140/90 mmHg)**: 27% (Feb'12), 46% (Feb'13), 46% (June'13), 59% (Jan'14), 67% (June'14)
- **Normal Blood Sugar (A1c <8.0%)**: 18% (Feb'12), 42% (Feb'13), 53% (June'13), 57% (Jan'14), 64% (June'14)
Outcomes | Reducing Hospitalization

% of patients with at least 1 hospitalization
(non-duals, 9+ attestations)
CMHC ER Visits Per 1000 Member Month (attestation method)
Initial Estimated Cost Savings after 18 Mos.

- **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
Lessons Learned

• Demonstration Projects only demonstrate a lack of commitment and rarely change anything
• Payment innovation alone is insufficient to affect real change additional requirements include:
  – Highly engaged active management by the payer
  – Significant commitments of resource and time to provider training
  – Transparent use of data in decision-making
  – Eliminating excessively restrictive interpretations of HIPAA and 42CFR Part2
• A new business relationship between payers and providers
  – A contract is not a business relationship and contract compliance alone is ineffective management
  – Business is a partnership with both parties goals held equally valuable, mutual trust, shared values, and assured willingness to undertake risk
CHANGE

When the Winds of Change Blow Hard Enough, the Most Trivial of Things can turn into Deadly Projectiles.
Allowable Uses - TPO

Core health care activities for which health information can be used/shared with or without patient consent under HIPAA to avoid unnecessary interference with access to quality health care:

- Treatment
- Payment
- Healthcare Operations
Treatment (45 CFR 164.5010)

• Treatment means the
  – provision,
  – coordination, or
  – management

• of health care and related services by one or more health care providers, including:
  – coordination or management of health care by a health care provider with a third party,
  – consultation between health care providers relating to a patient, or
  – referral of a patient for health care from one health care provider to another.
Treatment

- Authorizations are not needed to use or disclose Personal Health Information (PHI) for treatment purposes.
- Treatment, by design, is broadly defined.
- Treatment covers the coordination or management of health care among providers or a third party “related services.”
Treatment

- Treatment includes not just health care, but also, “related services.”
- “Related services” can include social, rehabilitative or other services associated with health care.
- HHS believes disclosures for treatment purposes are appropriate for timely and quality treatment.
Treatment

The following, when undertaken on behalf of a single consumer (not a population) are treatment activities:

- Case management
- Care coordination
- Disease management
- Health promotion
- Outreach programs
• Individuals have the right to request restrictions on how a covered entity will use and disclose PHI about them for treatment, health care operations and payment.

• A covered entity is not required to agree to an individual’s request for restriction, but is bound by any restrictions to which it agrees. (45 CFR 164.522(a))
A word about “liability”

• Both 42 CFR Part 2 and HIPAA are frequently interpreted in an unnecessarily restrictive manner by privacy officers, organizations, and general counsel.

• An Important Distinction for CEOs
  - Courts give Orders
  - Your lawyers give advice

• CEOs must manage and balance many types of liabilities:
  - Financial  – Legal  – Operational
  - Clinical  – Public Relations
Most Important Principles

- Perfect is the enemy of good
- Use an incremental strategy
- If you try to figure out a comprehensive plan first, you will never get started
- Apologizing for a failed prompt attempt is better than apologizing for a missed opportunity
PLANNING

Much work remains to be done before we can announce our total failure to make any progress.
Websites

- Missouri CMHC Healthcare Homes
  http://dmh.mo.gov/mentalillness/mohealthhomes.html

- Healthcare Home Source documents Page
  http://dmh.mo.gov/mentalillness/introcmhchchch.html

- NASMHPD Technical Reports