Missouri Health Home Initiative
Southern Legislative Conference, July 19, 2015
Development (2010-2011)

Time-limited enhanced federal funding

Recession-driven budgets

Frustration with current models/outcomes
“Fathers” of the Initiative

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Behavioral Care Outcomes

- The mentally ill in public care lose 25 years of life expectancy, largely from poorly managed medical conditions

- Smoking
- Inactivity
- Obesity
- Underdiagnosis
- Inadequate treatment
- Polypharmacy
Skewed Medicaid Cost Drivers

- 5 percent of non-elderly Missouri Medicaid enrollees generated 52.3 percent of Medicaid hospital costs in FY 2012.
- “Superutilizers” have significant health problems.
- Top priority task: identify them and better manage their care.
Implementation

- Behavioral Health Homes
  - 28 Community Mental Health Centers (120 clinic sites)
  - Enrollment: 19,780
  - Nurse manager arranges primary care services
- Incorporate management of DM 3700 demonstration project for high-cost (>\$50K) schizophrenic, bipolar or depressive patients (about 3,500 patients)
Implementation

- Primary Care Health Homes
  - Initially, 18 FQHCs (67 clinic sites) plus 6 hospitals (36 clinic sites)
  - Enrollment: 14,981
  - Initial “zero sum” funding expectation
  - 2014 legislative authorization to add 11 providers
Defining Medical Conditions

- Medical cost > $2,600 and two or more of:
  - Diabetes
  - COPD/Asthma
  - Cardiovascular (blood pressure, lipids, CHF)
  - BMI > 25
  - Developmental disability
  - Tobacco use

- Behavioral – one of above with serious mental illness
Care Management Services

- PMPM payment for:
  - Health home director (1:2,500)
  - Nurse care manager (1:250)
  - Care coordinator (1:500)
  - Behavioral health consultant (primary care)
  - Primary care physician consultant (behavioral)
  - Administration
  - Health information system
# 18-Month Estimated Savings Evaluation

<table>
<thead>
<tr>
<th>Health Home</th>
<th>Enrollees</th>
<th>PMPM Savings</th>
<th>Total Savings</th>
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<tbody>
<tr>
<td>CMHC</td>
<td>20,031</td>
<td>$76.33</td>
<td>$15.7M</td>
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<tr>
<td>PCHH</td>
<td>23,354</td>
<td>$30.79</td>
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<tr>
<td>Total</td>
<td>43,385</td>
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<td>DM 3700</td>
<td>3,560</td>
<td>$614.80</td>
<td>$22.3M</td>
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Lessons Learned

• Behavioral care offers savings and outcome improvement opportunities.
• Targeted populations should reflect the best opportunity for care improvement and savings.
• Local providers are the preferred source of care management services.
• Efforts to formalize external care collaboration arrangements may draw resistance.
Lessons Learned

• Trust among the various stakeholders is key.
• Effective sharing of data through HIT is needed.
• Primary care case management services require funding and plenty of training.
• The savings of health homes are extracted from hospital payments. Hospitals need to be committed to primary care alternatives.
• Savings accrue to the payer. Reinvesting some savings with providers would replicate the cycle.