

# **69<sup>th</sup> Annual Meeting of the Southern Legislative Conference**

## **Medicaid Behavioral Health Homes Integrating Services- Overview and Implementation Advice**

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# RECOGNIZE THE HEALTH HOME OPPORTUNITY!

- An innovative initiative to provide services in a new delivery model to high utilizer individuals to address both Behavioral Health and Physical Health issues involved with their chronic conditions
- Offers states the opportunity to provide Medicaid coverage, at an enhanced Federal Medicaid Participation Match Rate of 90%
- Win-Win result on improving access, use and coordination of appropriate care, reducing higher cost facility-base services



# SECTION 2703 of the AFFORDABLE CARE ACT

## Defines Health Home Initiative Program

- Medicaid State Plan Option (Amendment)
- Medicaid eligible individuals with chronic conditions
- Providers will integrate and coordinate all primary, acute, behavioral health and long term services and supports

# CURRENTLY 27 HEALTH HOME PROGRAMS IN 19 STATES as of 3/2014

- AL, ID, IO (2), KS, MD, ME (2), MI, MO (2), NJ (2), NY (2), NC, OH, OK (2), RI (3), SD, VT, WV, WA & WI
- Program is implemented in states whose State Plan Amendment is approved by CMS, and continues for a maximum of 8 quarters per individual

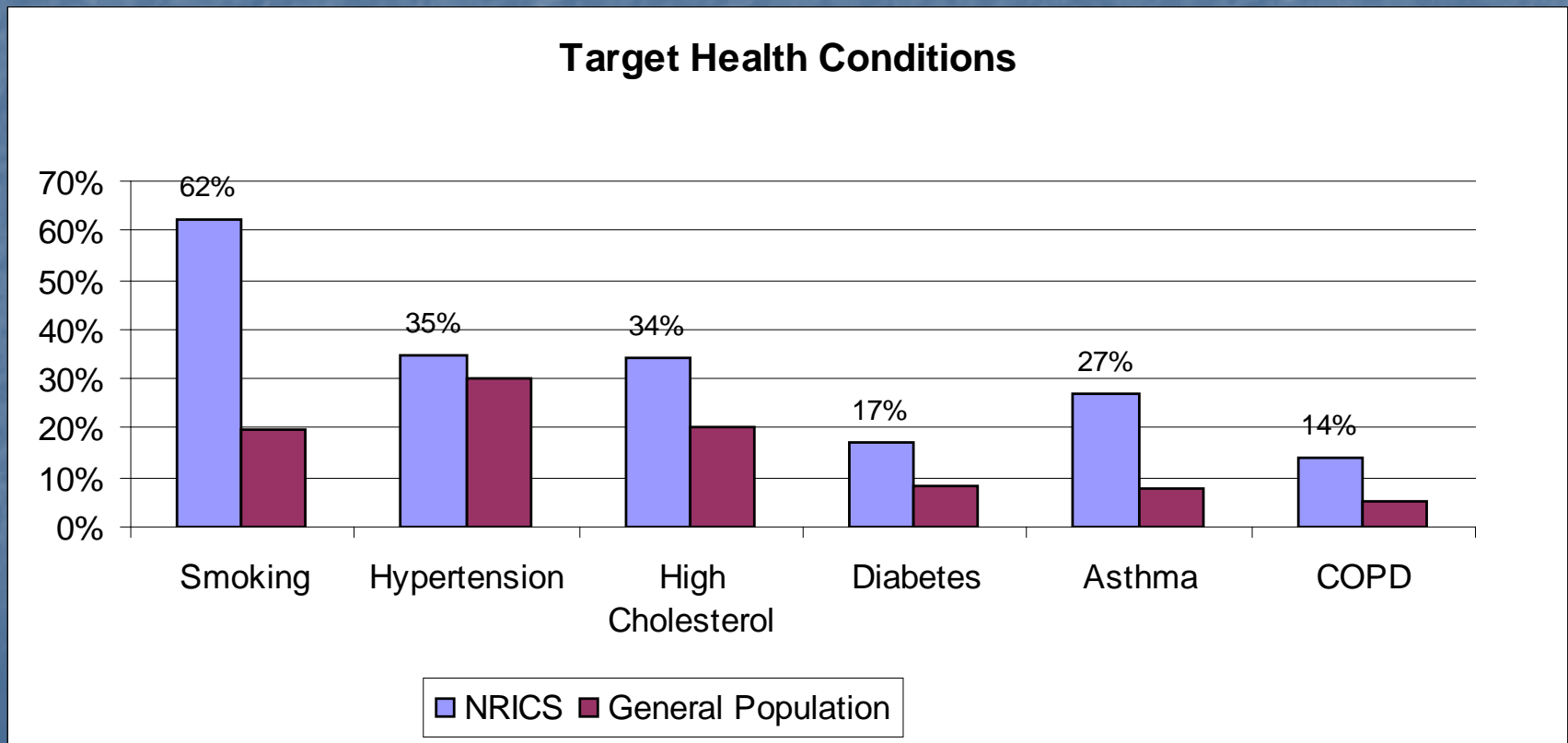
# DEFINE THE POPULATION

CMS Requires that the Health Home Populations meet one of the following criteria:

- Have two chronic conditions, or
- Have one chronic condition and be at risk for a second, or
- Have one Serious Mental Illness (SMI)

# TARGET CHRONIC CONDITIONS

## 2013 DATA FROM RI HEALTH HOME PROGRAM



# CORE CMS HEALTH HOME SERVICES

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support Services
6. Referral to Community and Social Support Services

# CMHO HEALTH HOME STATE PLAN AMENDMENT TEAM

- CMHO/Agency Representatives
- Trade Organizations Representatives
- State Medicaid Agency Representative
- DMH/SA Program and Fiscal Staff
- Managed Care Organizations
- Transformation Advisory Group

# THE CMHO HEALTH HOME TEAM (RI)

- A Master's Level Team Coordinator (1 FTE)
- A Psychiatrist (0.5 FTE)
- A Registered Nurse (2.5 FTE)
- A Licensed and Master's prepared mental health professional (1 FTE)
- A Community Support Professional – Hospital Liaison (1 FTE)
- Community Support Professionals (5.5 FTE)
- A Peer Specialist (0.25 FTE) As the resource becomes available
- **Total of 11.25 FTEs**



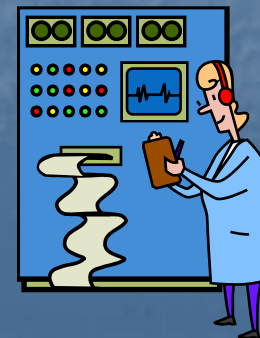
# THE CMHO HEALTH HOME TEAM

- Other Health Home team members may include, but are not limited to:
  - primary care physicians
  - pharmacists
  - substance abuse specialists
  - vocational/employment specialists
  - community integration specialists
  - affordable housing resources



# HEALTH HOME QUALITY MEASURES

- Goal Based Quality Measures:
  - Improve Care Coordination
  - Reduce Preventable Emergency Department (ED) Visits
  - Increase Use of Preventive Services
  - Improve Management of Chronic Conditions
  - Improve Transitions to CMHO Services
  - Reduce Hospital Readmissions
- Within each domain, measures include:
  - Clinical care
  - Experience of Care
  - Quality of Care



# VARIED STATE APPROACHES TO HEALTH HOMES

- **Iowa:** opportunity to strengthen primary care practices and PCMH certification for system transformation
- **New York:** align diverse care management initiatives and integrate siloed programs to promote accountability
- **Missouri:** improve coordination and transition of care, and integrate BH/PC to reduce hospitalizations
- **Oregon:** increase access to PCMH and allow Medicaid to be a key PCMH player in multi-payer strategy
- **RI:** coordinate siloed children's program, improve care management and integration of adult programs and facilitate access to primary care for opiate affected individuals

# NATIONAL COMMON THEMES AND BEST PRACTICES

1. Comprehensive Care Management

2. Care Coordination

3. Health Promotion

1. Track care plan goals, MH/SA screenings and reassessment

2. Face to face contacts, case conferences and improve notification of admissions

3. Focus on patient engagement and address non-clinical needs

# NATIONAL COMMON THEMES AND BEST PRACTICES

- 4. Comprehensive Transitional Care
  - 5. Individual and Family Supports
  - 6. Referral to Community Resources
- 4. Pharmacy coordination, hospital liaisons and home visits
  - 5. Assist to develop social networks, advance directives
  - 6. Develop resource manual, identify policies, procedures and accountabilities with community based groups

# EVALUATION OVERVIEW

- States must describe how to collect information from CMHOs, MCOs, Medicaid and Medicare for purposes of providing data for the 2017 Congressional Health Home Report, which will ultimately influence the value, extent and expanded use of this program, including:
  - Hospital Admission rates
  - Chronic Disease Management
  - Coordination of care for individuals with chronic conditions
  - Assessment of program implementation
  - Processes and lessons learned
  - Assessment of quality improvements and clinical outcomes
  - Estimates of cost savings

# IMPLEMENTATION EXPERIENCE

## ■ Financial Challenges

- Enrollees were going in and out of Medicaid eligibility, which created vacuums in reimbursement, coverage and treatment plan effectiveness
- Staff report that there should be a group home facility for more intensive SPMI clients that don't do well in a nursing home care as a more cost and clinically effective setting
- Some (medical) admissions may increase with coordinated access to needed care and better educated/empowered consumers

# IMPLEMENTATION EXPERIENCE

## Health Information Technology Challenges

- The barrier of information sharing will be the major factor limiting the effectiveness of care coordination
- Agency MIS systems are challenged to incorporate medical disorders, screenings, health risks, expanded medications, etc., into behavioral health software programs
- Health Home field needs technical support to aid standardization of integrated care data collection and reporting components
- Need process to interface medical records with hospitals, primary care, laboratories, pharmacies, etc., and data sharing features

# IMPLEMENTATION EXPERIENCE

## Clinical Challenges

- Almost 70% of RI SPMI Health Home clients have substance abuse, homelessness or unemployment issues affecting clinical outcomes
- It is challenging to separate care coordination from treatment when (necessarily) occurring in the same time period to address all of these issues
- It is also challenging to separate populations between Health Home and non-Health Home clients who must be treated (differently) by the same staff

# IMPLEMENTATION EXPERIENCE

- **Communication is Key**
  - Ongoing Provider Association and Consumer/Family Involvement is critical to address cultural issues
  - Provider Certification Agreement
    - State and Agency roles and responsibilities
    - Care coordination agreement templates with hospitals and MCOs
  - Health Homes Resource Manual
    - Program goals
    - Team functions
    - CMS outcomes
    - Event databases
    - Fee schedules
    - Auditing tool



# POSITIVE OUTCOMES REPORTED FROM STATES

- New York
  - 14% increase in PC visits
  - 23% decrease in hospital admissions and ER visits
  - 30% decrease in inpatient spending for enrollees
- Missouri
  - 8% decrease in ER visits
  - 13% decrease in ambulatory-sensitive hospitalizations
  - Average savings to state of \$52 PMPM
- Rhode Island (one agency)
  - 13% decrease in medical admissions
  - 15% decrease in psychiatric admissions
  - PCP identified for 85% of clients (up 30%)

# WHAT ARE THE CONSUMERS SAYING SO FAR....?

- Less medication errors and omissions (unintentional and intentional!)- Prescription Monitoring Program
- Hospital liaisons and peer specialists very helpful
- Positive response from their PCPs (welcoming help with difficult patient population)
- Major life improvement- physical ailments have inhibited behavioral health recovery, and vice versa
- Better grasp of treatment compliance issues
- Higher self esteem in primary care settings

# SERVICE AND STRUCTURE IMPACT OF HEALTH HOMES INITIATIVES

A number of states have experienced changes to service delivery and payment systems influenced by Health Homes, including:

- Increase in Patient Centered Medical Homes
- Integrated care demonstrations
- Managed care redesigns
- Medicaid Accountable Care Organizations
- State Innovative Model (SIM) Design Grants
- Coverage Expansion

**THANK YOU!**

**QUESTIONS AND CONTACT:**

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