Making the Ohio Medicaid Business Case for Integrated Physical and Behavioral Health Care:

A Discussion of Research Findings

HEALTH MANAGEMENT ASSOCIATES

Ohio Colleges of Medicine
Government Resource Center

Project Funded By:

Northeastern Ohio Universities
COLLEGES OF MEDICINE & PHARMACY
Best Practices in Schizophrenia Treatment (BeST) Center

The Health Foundation of Greater Cincinnati

Agenda

- Welcome and Acknowledgements– Lon Herman
- Remarks from the Office of Health Transformation
- About the BeST Center
- Review Study Results
- Lessons Learned from Missouri
- Questions and Brief Discussion
- Overview of Local Initiatives
  - Community Support Services, Inc.
  - Child Guidance and Family Solutions
  - Center for Families and Children
- Questions and Brief Discussion
- Wrap Up

Welcome and Acknowledgments

- BeST Center at NEOUCOM
- Center for Families and Children, Cuyahoga County
- Child Guidance & Family Solutions, Summit County
- Community Support Services, Inc., Summit County
- Governor's Office of Health Transformation
- Health Foundation of Greater Cincinnati
- Health Management Associates
- The Margaret Clark Morgan Foundation
- Ohio Colleges of Medicine Government Resource Center
- Ohio Department of Alcohol and Drug Addiction Services
- Ohio Department of Job and Family Services
- Ohio Department of Mental Health

Best Practices in Schizophrenia Treatment (BeST) Center

Established:

- In the Department of Psychiatry at NEOUCOM
- Through a generous grant from The Margaret Clark Morgan Foundation

Mission:

- Promote recovery and improve the lives of as many individuals with schizophrenia as quickly as possible
- Accelerate the use and dissemination of effective treatments and best practices
- Build the capacity of local systems to deliver state-of-the-art care to people affected by schizophrenia and their families

The BeST Center offers:

- Training and consultation
- Education and outreach activities
- Services research and evaluation

Ohio Medicaid Claims Analysis

Alicia D. Smith, Senior Consultant – Health Management Associates
Lorin Ranbom, Director – Ohio Colleges of Medicine Government Resource Center

Why Medicaid Programs Care About Integrated Physical & Behavioral Health

Nationally,

- Medicaid is the single largest payer for mental health services and the dominant purchaser of antipsychotic medications in the U.S.
- By 2014, Medicaid spending is expected to increase annually by 8%for mental health services and by 6% for addiction treatment services.
- Roughly 12% of Medicaid beneficiaries received mental health or addiction treatment services in 2003, accounting for almost 32% of total Medicaid expenditures.
- Nearly twenty-seven percent of all inpatient hospital days paid for by Medicaid in 2003 were for mental health and addiction treatment treatments.
- Beneficiaries with mental health and substance use disorders (SUD) are more likely than other Medicaid beneficiaries to have one or more costly co-occurring physical health conditions.

Other States' Analyses

- States are increasingly interested in addressing multiple chronic conditions among Medicaid beneficiaries, particularly among adults with serious mental illness (SMI)
- California, Maine and Missouri sought to understand the frequency and fiscal impact of co-occurring mental illness and chronic physical health conditions of Medicaid beneficiaries
- Increased morbidity and mortality for individuals with SMI is largely due to preventable medical conditions

Medical conditions among adults with SMI:

- Cardiovascular Disease
- Hypertension
- Diabetes
- Obesity
- Respiratory Conditions
- Metabolic Disorders

Data and Methodology

Medicaid de-identified data for SFY 2008 and 2009:

- FFS claims, including MACSIS (from ODADAS and ODMH) and ODD claims;
- MCP encounters, and
- Monthly eligibility and demographics.

Pseudo-pricing of managed care encounters

- DRG assignment and pricing of inpatient hospital visits.
- Pricing of professional, institutional, and prescription drug encounters using Medicaid FFS payment averages.
- Adjustment of prescription drug encounters to reflect manufacturers rebate.
- Triangulation with MCP capitation payments.
- Two percent upward adjustment to equal capitation amounts.

Data and Methodology

Identifying Ohio Medicaid Adults with SMI:

- Used ICD-9 diagnosis criteria on claims/encounters
- Based upon primary diagnosis
- Must have at least two encounters on separate days with the primary diagnosis to be included
- SMI Hierarchy, one of the following conditions assigned to each client:
  - Schizophrenia
  - Psychosis
  - Bipolar disorder
  - Post traumatic stress disorder
  - Adjustment disorder
  - Anxiety
  - Substance use disorder
  - “Other" disorders (personality disorder, psychological consequences of brain disorder, and sexual disorder)
- Individuals with multiple diagnoses were assigned the diagnosis that was highest on the hierarchy

Non-SMI Adults

- All other Adults excluding Developmentally Disabled patients.
- Some DD are included in the SMI (because they also have one of the SMI conditions).

Data and Methodology

Assignment of each person to one of the following categories:

- *Non-Specialty*: Did not use the Community Mental Health System
- *Specialty Only*: Only used the Community Mental Health System for diagnosis and treatment of mental health conditions
- *Both*: Used the Non-specialty and specialty systems to diagnose and treat mental health conditions.

Identification of selected chronic physical health conditions and co-occurring substance abuse:

- Based upon primary and secondary diagnoses.
- Must have at least two encounters on separate days with the diagnosis to be included.

Hospital admissions / ED visits:

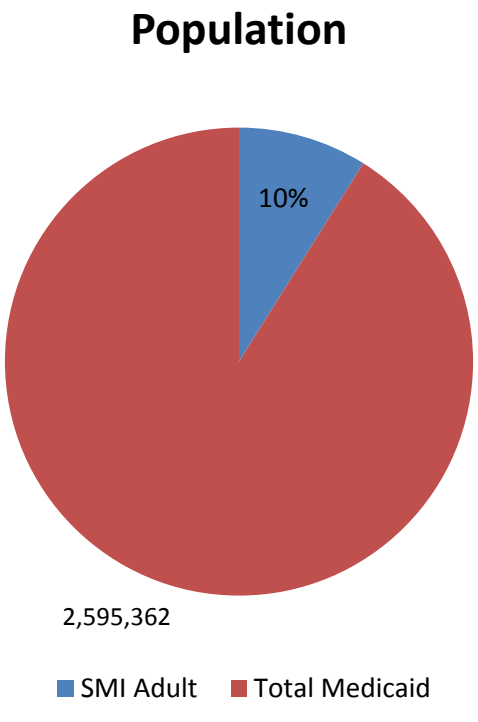
- Ambulatory Care Sensitive Conditions - used AHRQ Prevention Quality Indicators software.
- Hospital readmissions - used 3M Potentially Preventable Re-admissions software.

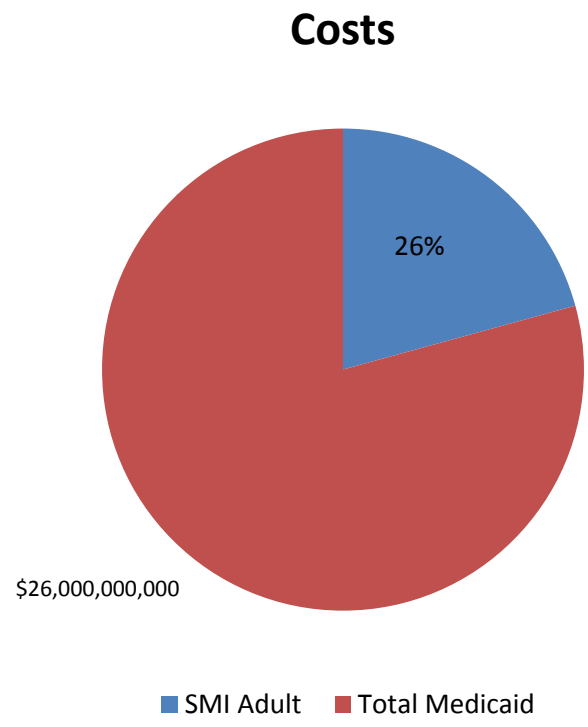
Frequency Count by Diagnosis

SMI Qualifying Condition	Number	Avg. Annual Expenditures
Schizophrenia	39,021	$ 784,961,862
Psychosis	9,486	$ 268,079,490
Bipolar	52,547	$ 663,630,548
PTSD	6,150	$ 50,688,779
Depression	86,759	$ 1,062,375,477
Adjustment	14,382	$ 139,939,463
Anxiety	26,545	$ 273,823,715
Substance Use Disorder	17,074	$ 100,163,660
Other	2,013	$ 43,367,571
Total SMI	**253,977**	**$ 3,387,030,569**

Depression is the most frequently identified diagnosis. Individuals with Psychosis account for roughly 4 percent of Adults with SMI.

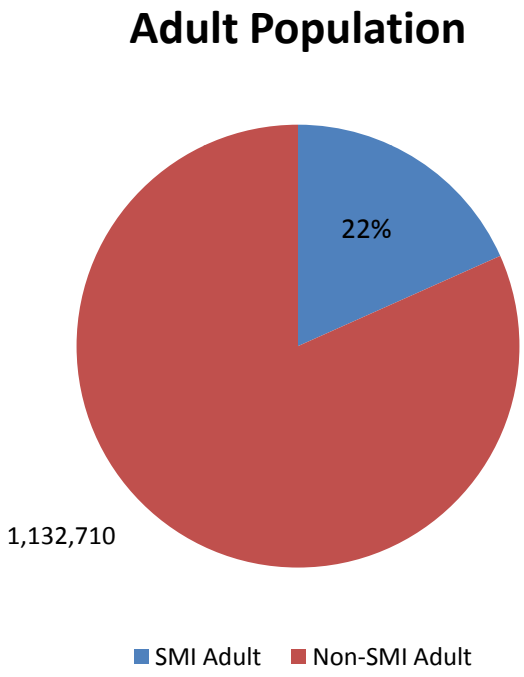
Adults with SMI as a Percentage of the Total Medicaid Population

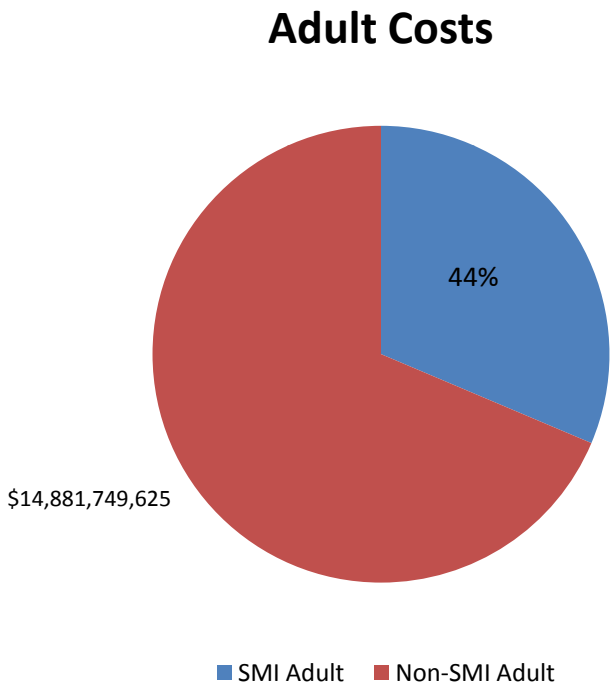




From FY 2008-2009, adults with serious mental illness (SMI) represented about 10% of the Medicaid population and 26% of total Medicaid expenditures.

Adults with SMI as a Percentage of Non-SMI Adult Medicaid Beneficiaries





Compared with All Other (Non-SMI and Non-DD), adults with SMI represented 22% of the Medicaid population and 44% of Medicaid spending from FY 2008-2009.

Average Annual Expenditures Per Person

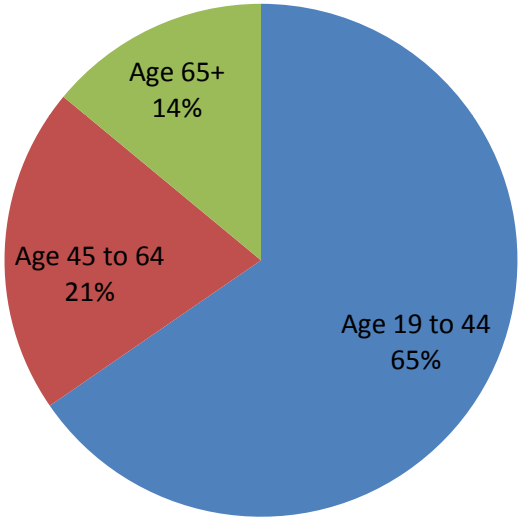
All Medicaid	$ 5,009
Non-SMI Adults	$ 8,151
SMI Adults	**$ 13,064**
Psychosis	$ 28,260
Schizophrenia	$ 20,116
Depression	$ 12,245

Depression is the most frequently identified diagnosis and the highest annual Medicaid expenditure among adults with SMI.

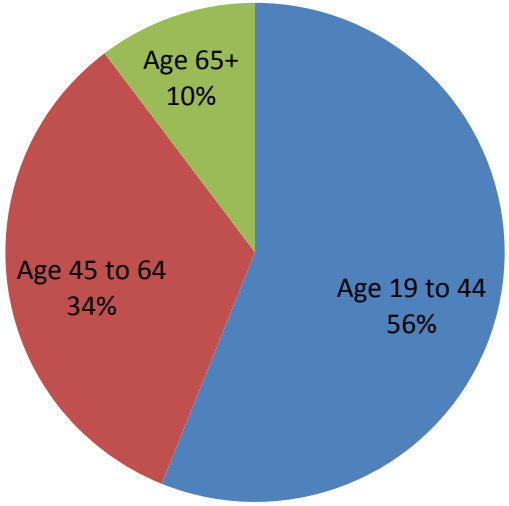
Schizophrenia is less frequently diagnosed than depression; however, services for individuals with schizophrenia are the second highest total annual Medicaid expenditure and the third highest per person expenditure.

Demographics

Non-SMI Adults

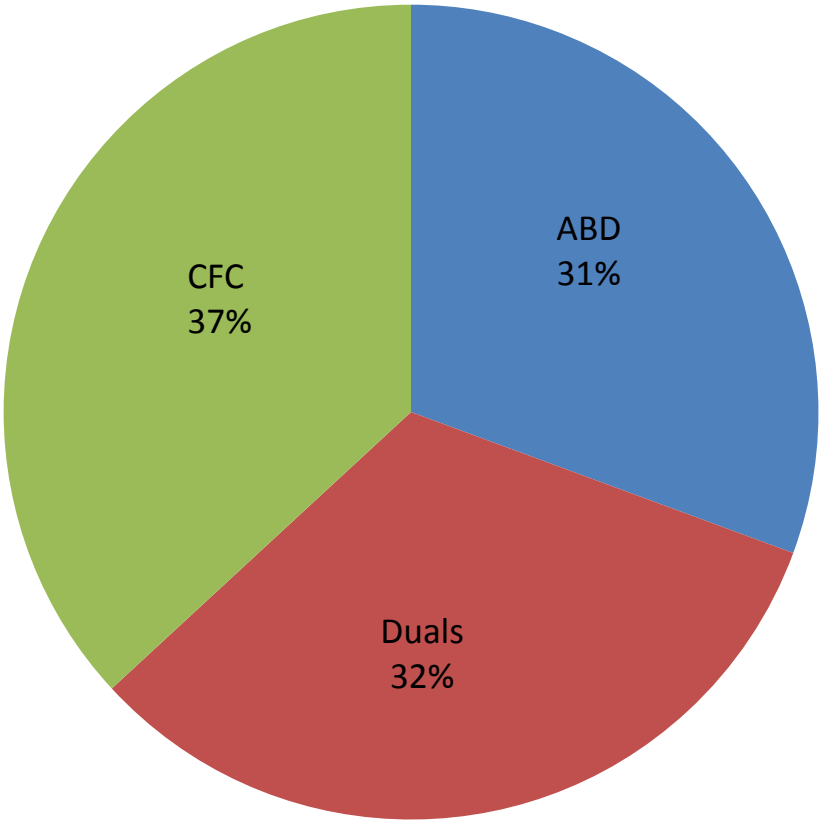


SMI Adults



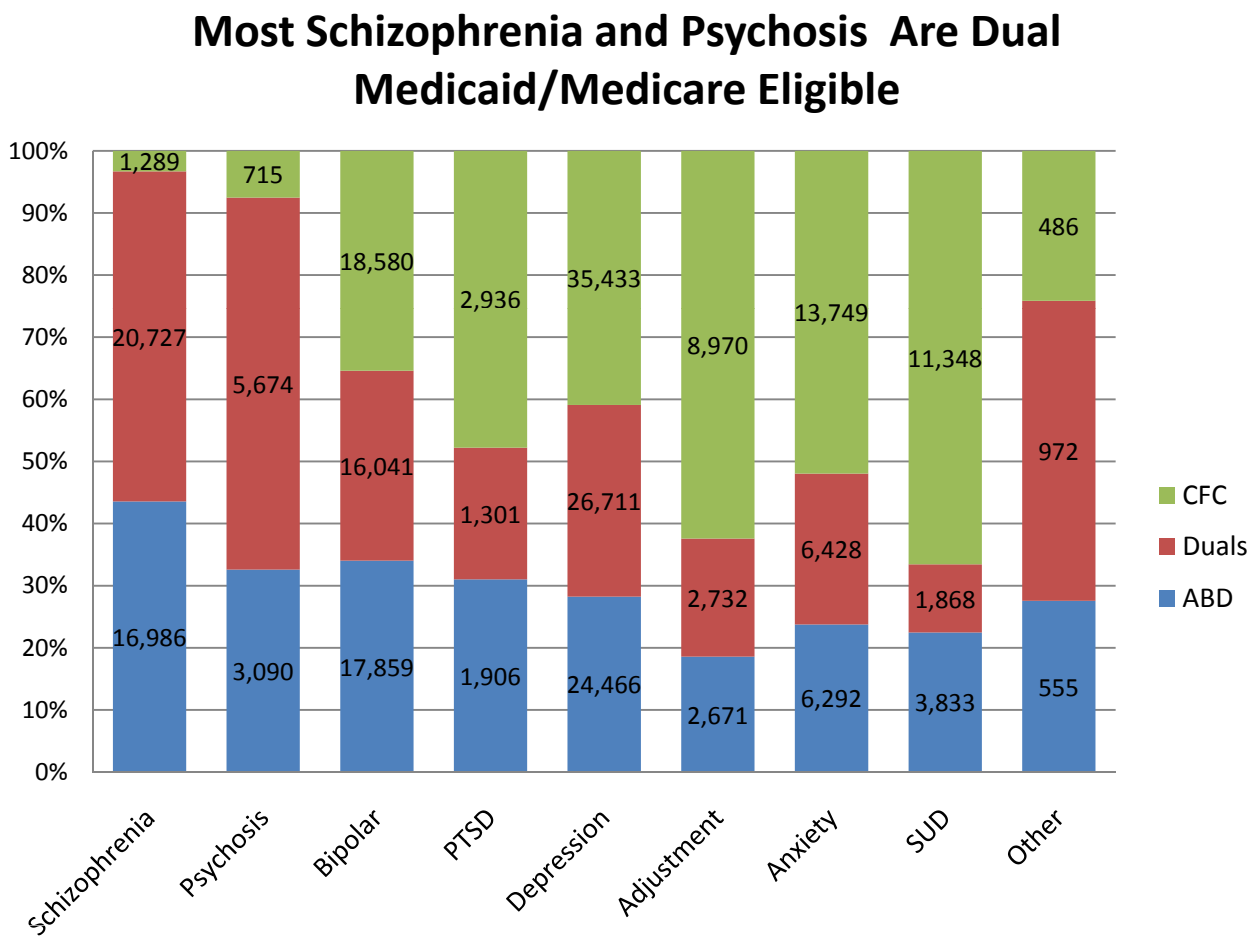
Adults with SMI have a lower representation in both the aged and young adult population. However, adults with SMI are over-represented in the 19-44 age group.

Medicaid Eligibility Status of SMI Adults



Roughly a third of SMI adults are in each eligibility category.

Adult SMI Eligibility Status by Diagnosis

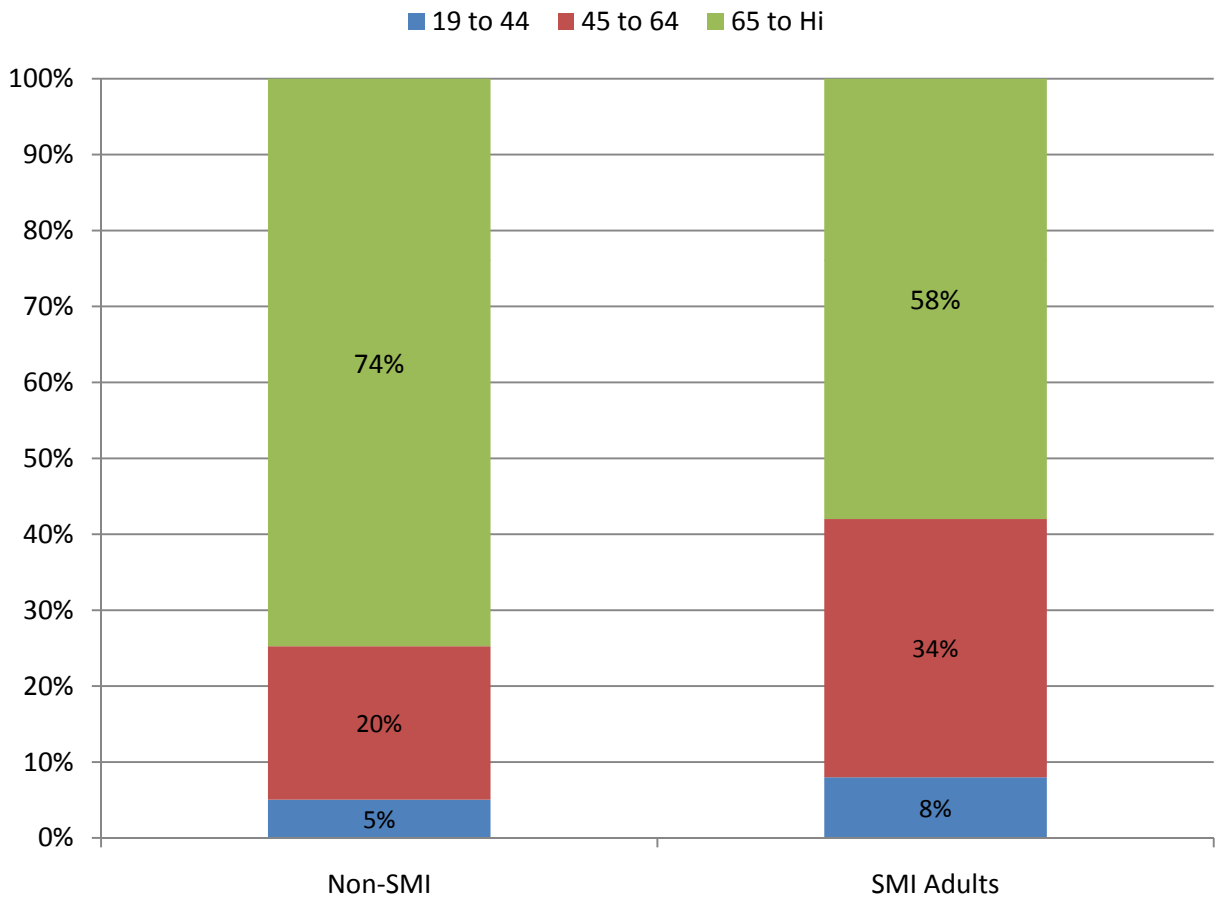


Some differences by diagnosis:

The majority of adults with schizophrenia and psychosis are Dual Medicare and Medicaid eligible.

Those with substance use disorder (SUD), adjustment disorder, and anxiety tend to be eligible under CFC.

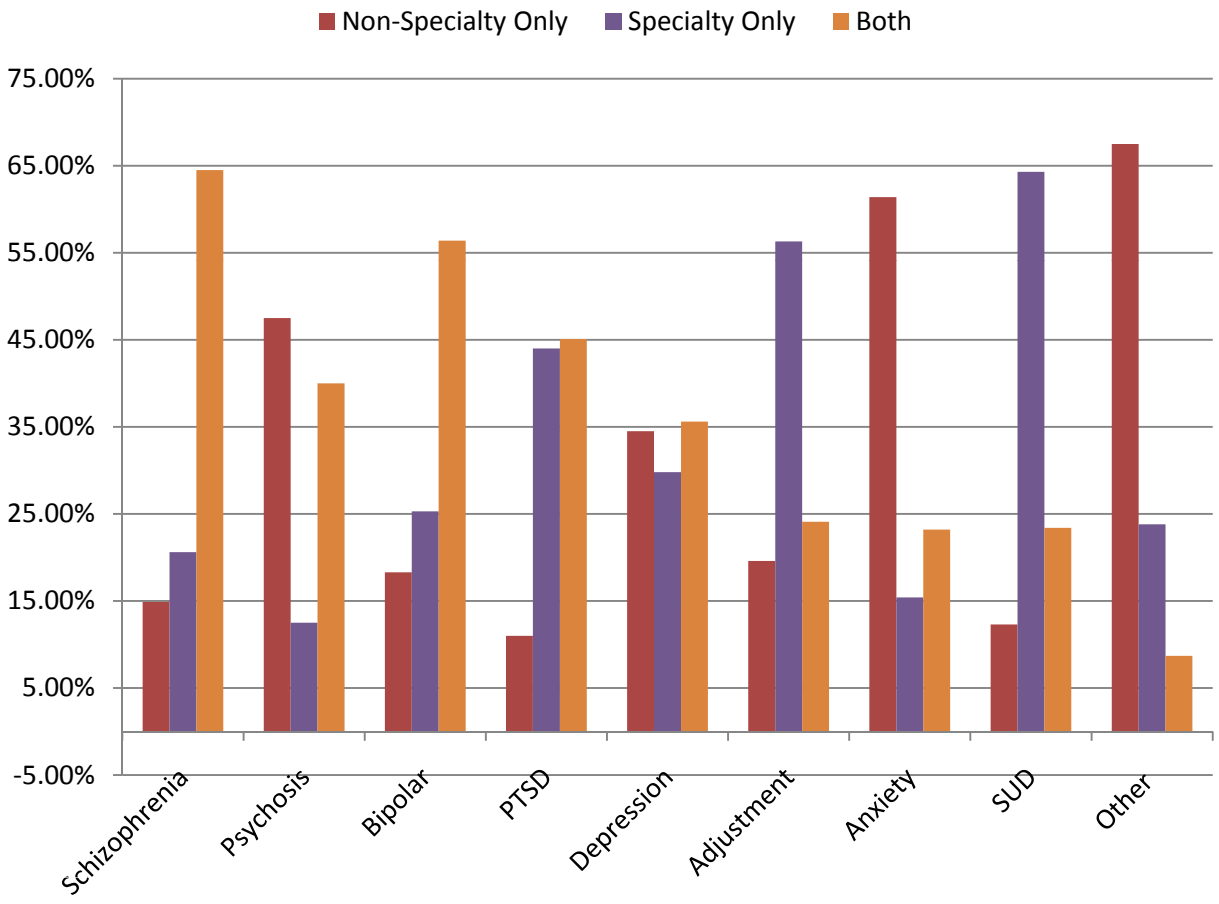
Age of SMI Adults in Nursing Facilities



A larger proportion of adults with SMI reside in long-term care facilities when compared to non-SMI adults.

Among those residing in long-term care facilities, 42% of SMI adults versus 25% of non-SMI adults were under 65 years of age.

Percentage of SMI Adults Served in Specialty BH System

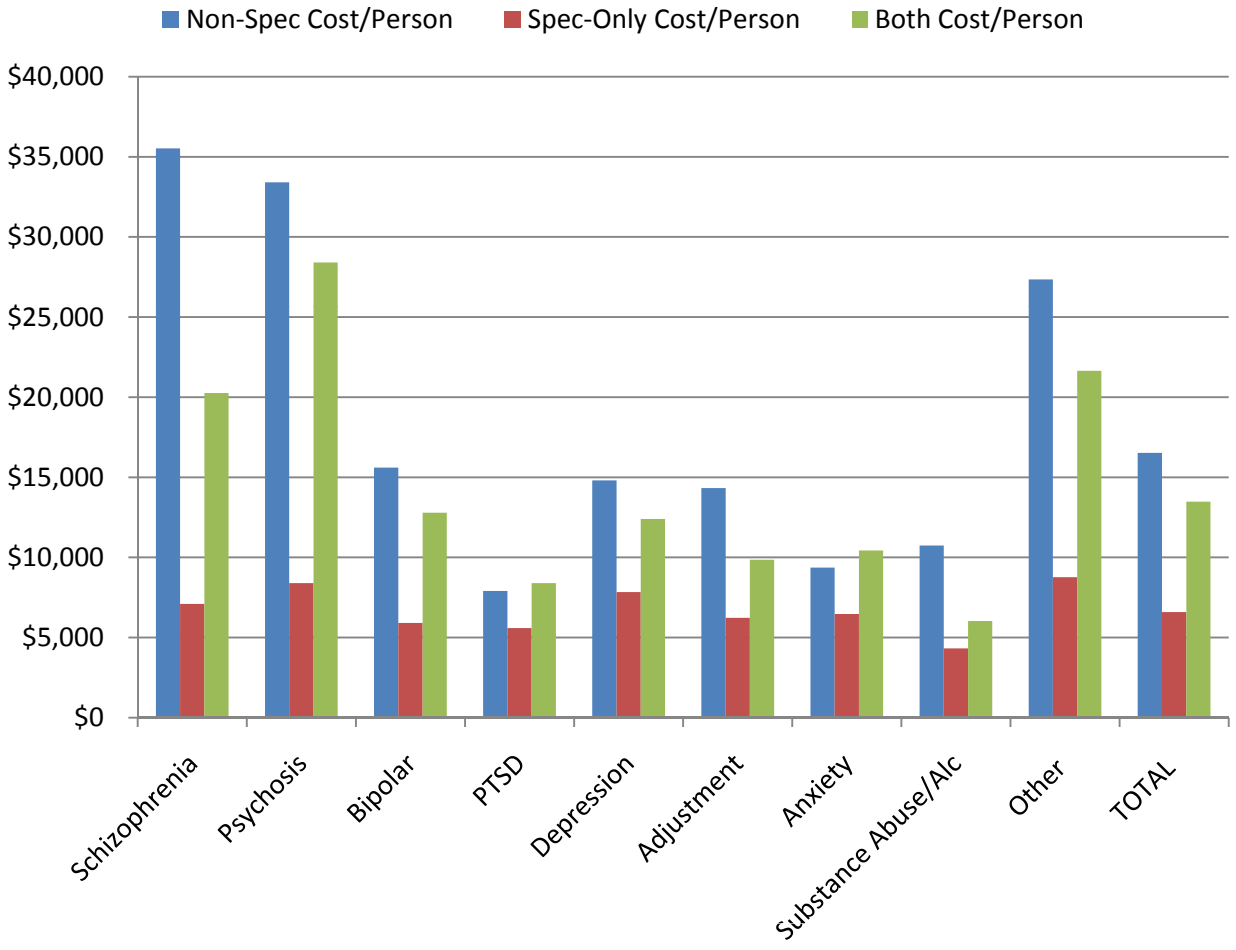


Approximately 29% of adults with SMI do not receive services in a specialty behavioral health system.

Adults with adjustment disorder or substance abuse were mostly served in the specialty system.

The majority of adults with schizophrenia and bipolar disorder receive services from both systems.

Avg. Annual Cost/Per Person By System

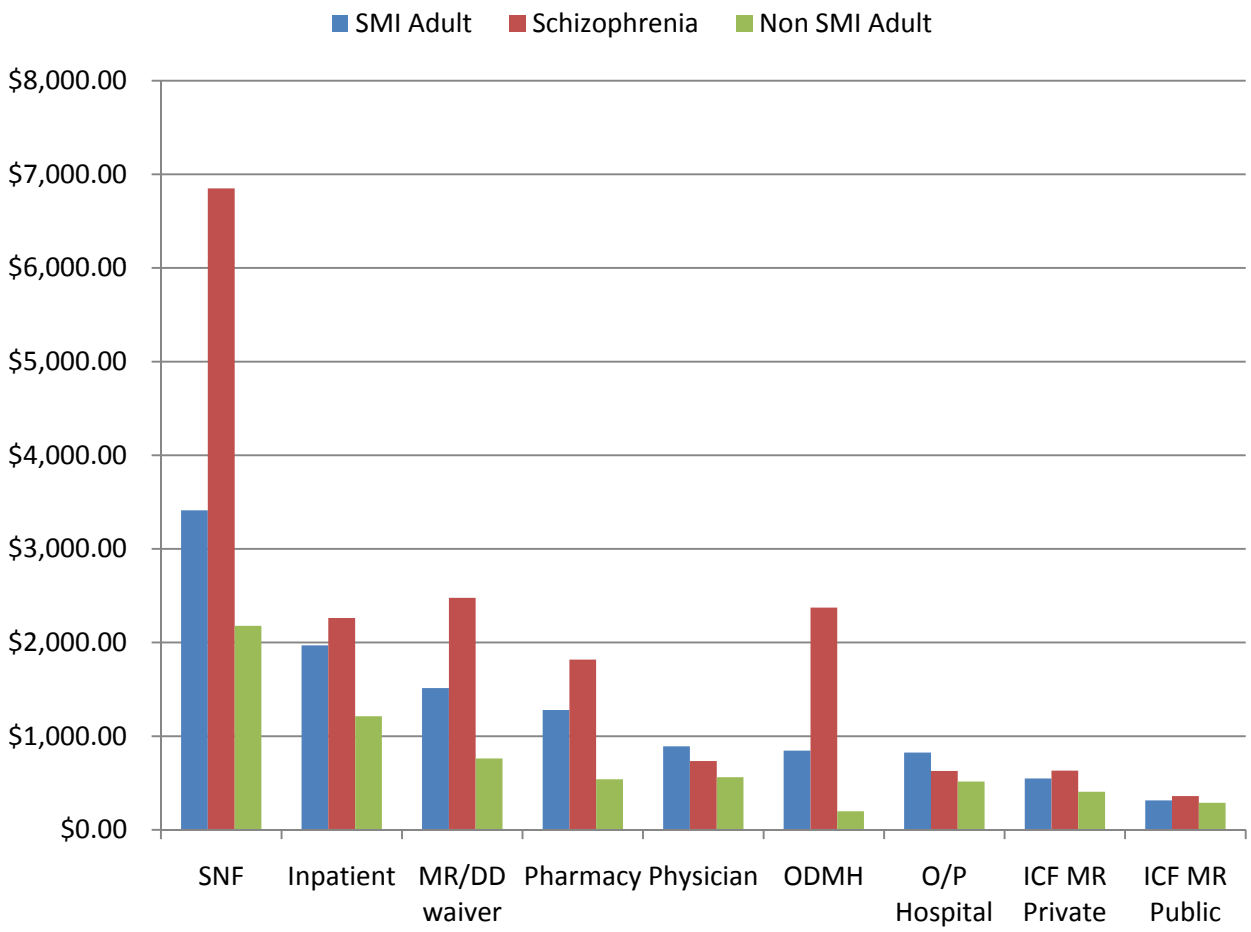


Medicaid expenditures are highest SMI adults served in the Non-Specialty system.

Individuals served only in the Non-Specialty system tend to be older and have more co-morbid physical health conditions.

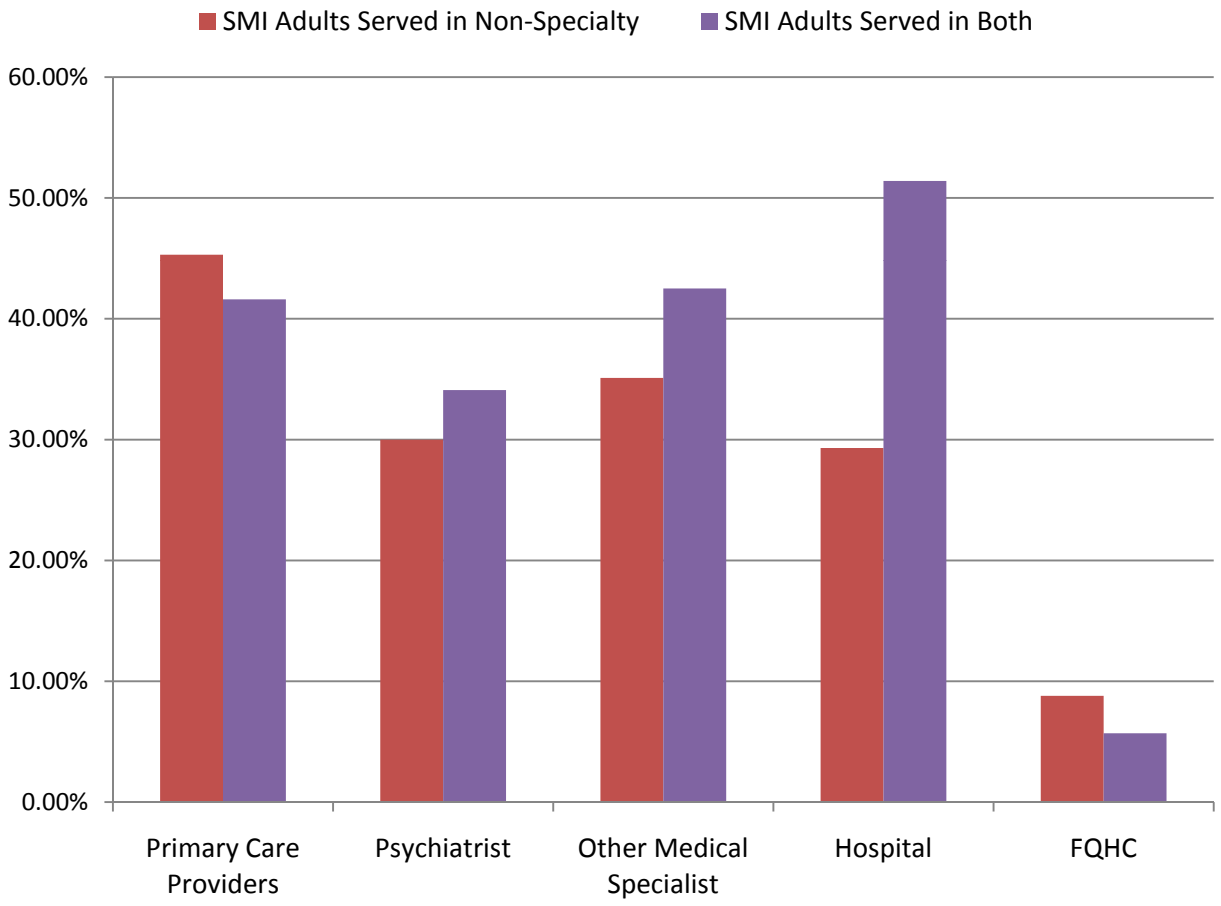
Individuals in the Specialty Only system are more likely to have CFC and are younger.

Average Annual Expenditures Per Person by Service



For adults with schizophrenia, the cost of nursing facilities, MR/DD waiver, and medication are about three times greater than those of non-SMI adults.

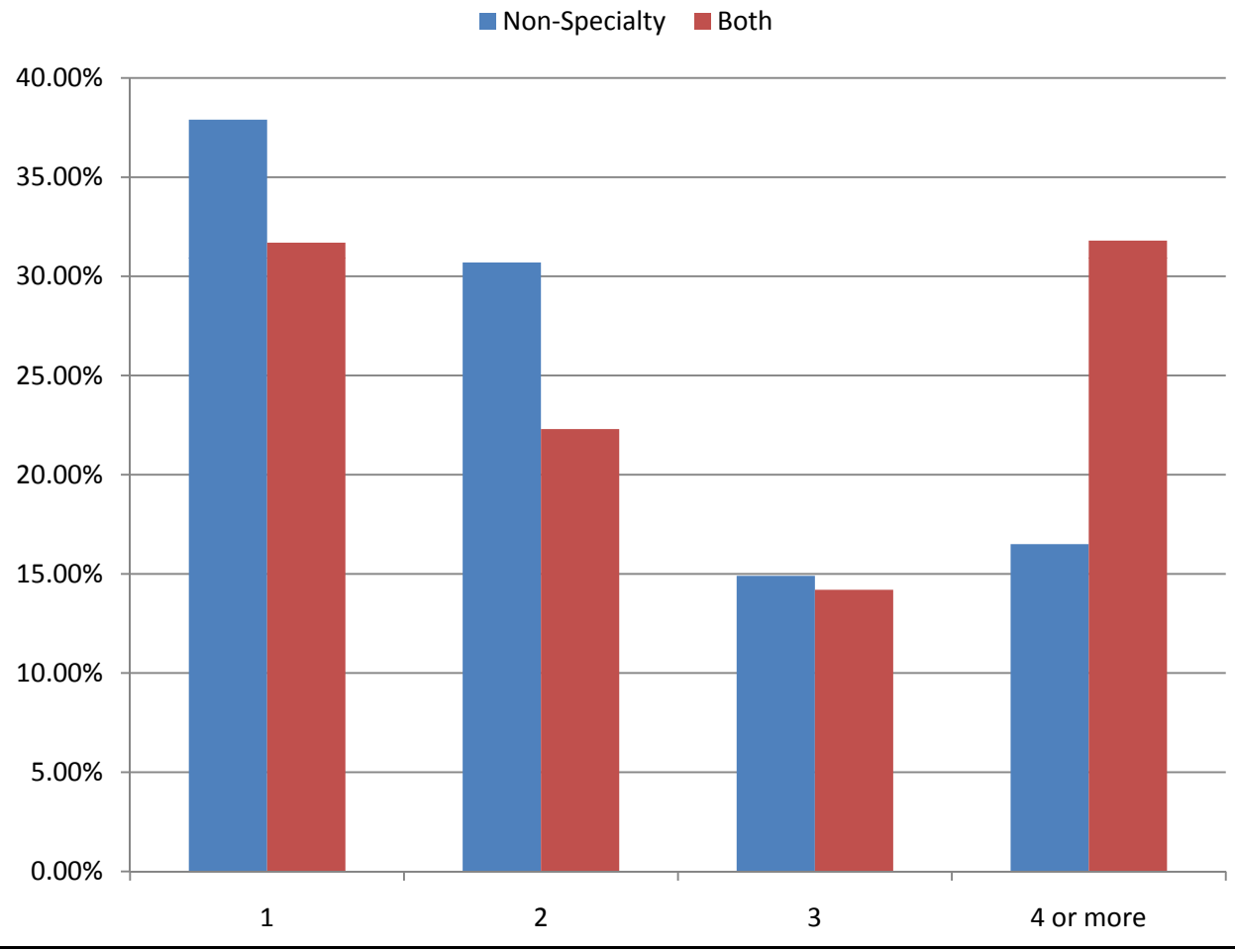
Treatment of SMI Conditions in the Non-Specialty System



SMI adults seek treatment for mental illness conditions in the Non-Specialty system regardless of whether they also receive services in the Specialty system.

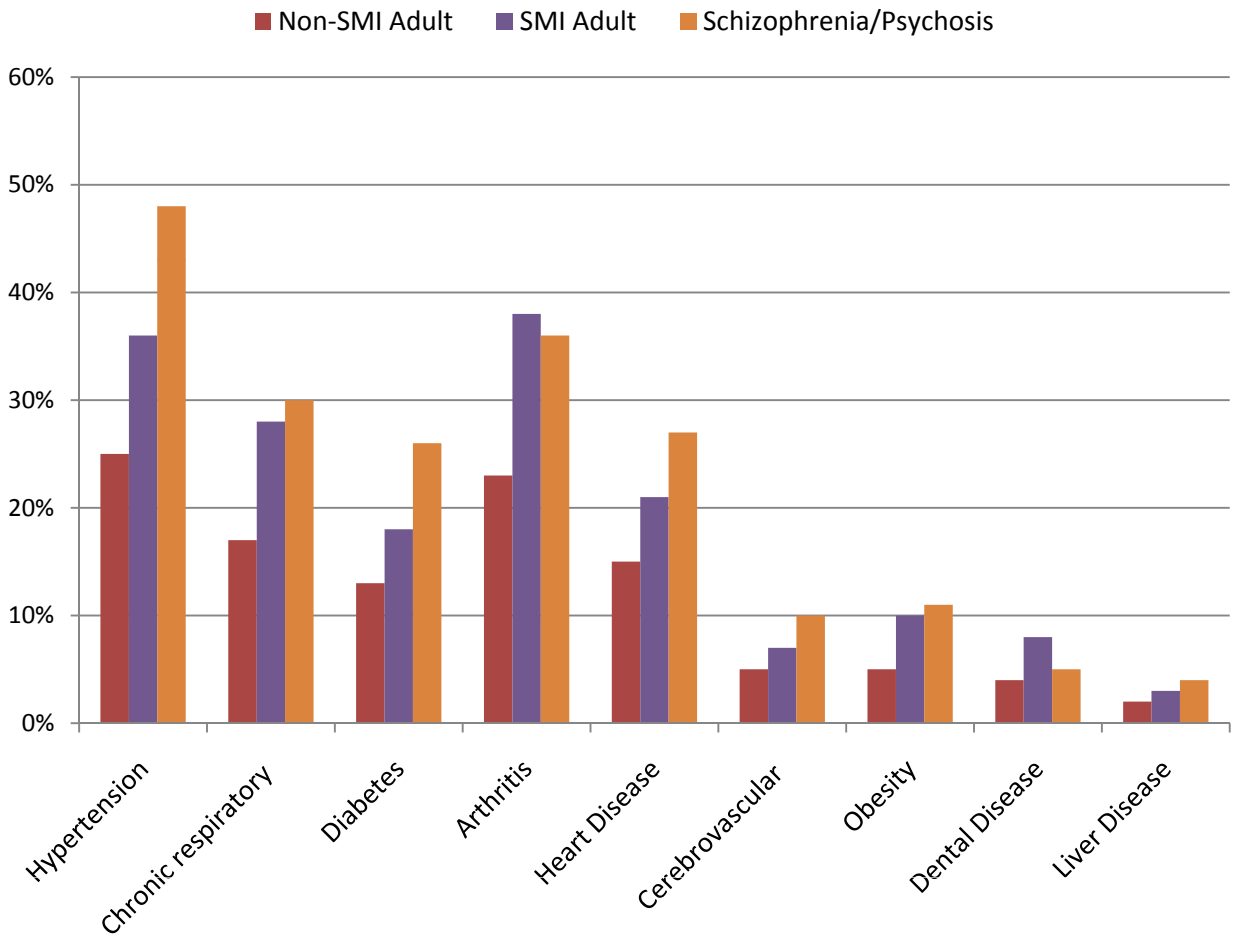
Significant amounts of diagnosis and treatment of mental illness conditions is occurring among primary care providers.

Number of Non-Specialty Providers Assessing and Treating SMI Conditions Per Client



Among individuals receiving mental health diagnosis and treatment in the Non-Specialty system, many have multiple providers assessing and treating their mental health condition.

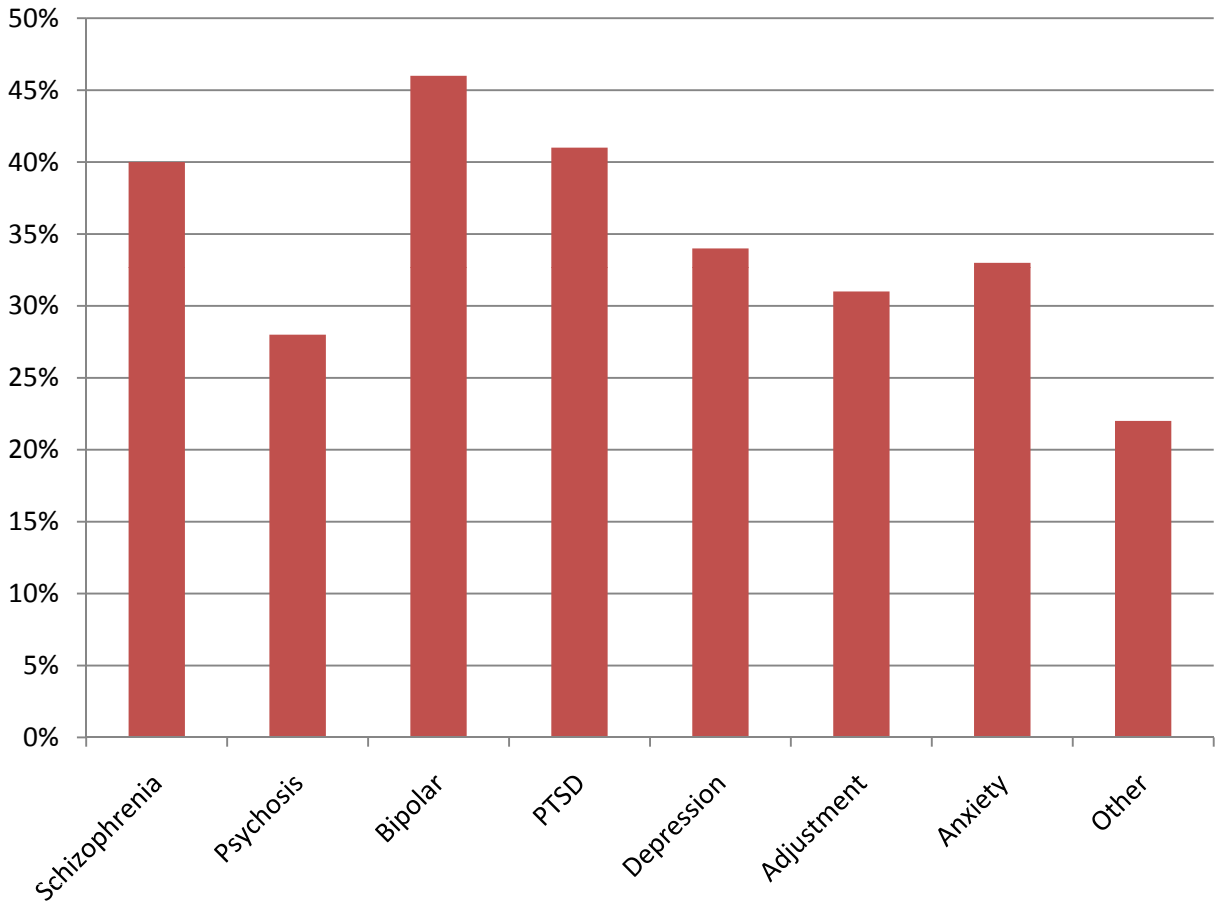
Co-Occurring Chronic Physical Health Conditions



The rate of co-occurring chronic physical health conditions is higher among individuals with SMI, particularly high among those with schizophrenia and psychosis.

The higher incidence of respiratory conditions may be related to the very high incidence of tobacco use among individuals with SMI.

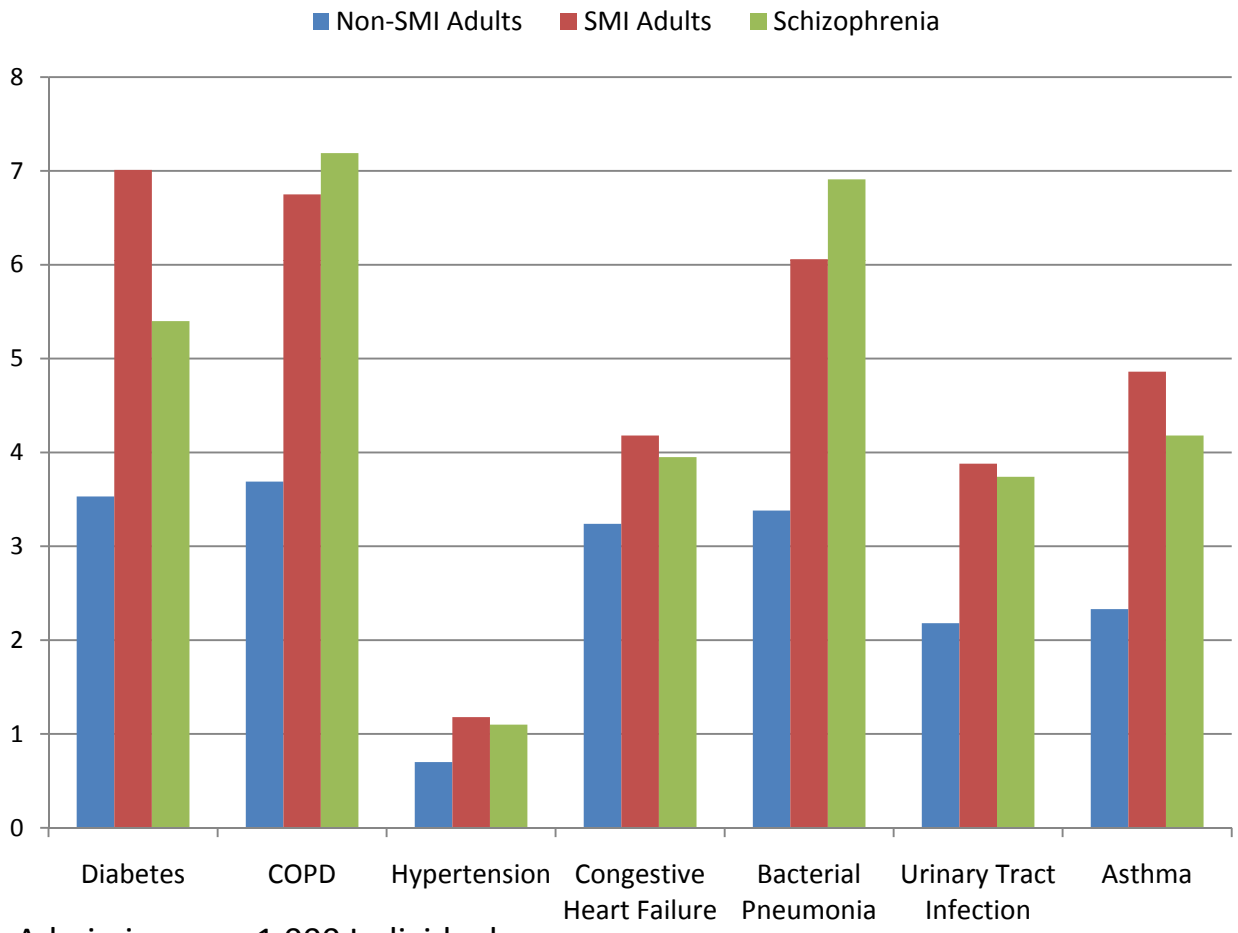
SMI with Co-Occurring Substance Use Disorder



Co-occurring Alcohol and Substance Use Disorder was identified in 22% to 46% of individuals with SMI .

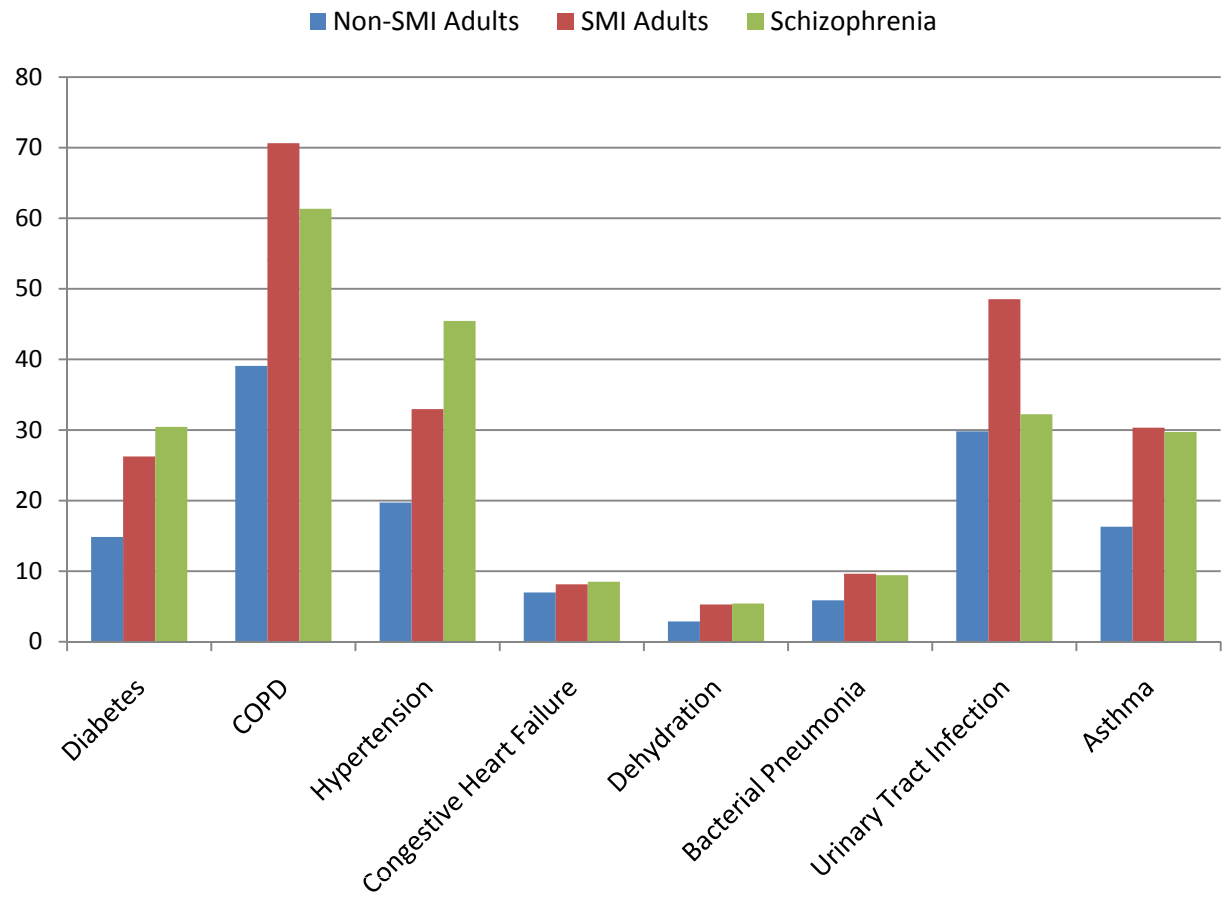
Rates of SUD are likely under reported.

Hospitalizations for Ambulatory Care Sensitive (ACS) Conditions



Adults with SMI have approximately twice the rate of hospitalization and ED visits for many ACSCs including diabetes, COPD, pneumonia, and asthma.

Emergency Department Visits for ACS Conditions



Visits per 1,000 Individuals

Adults with schizophrenia have over twice the rate of ED visits for hypertension and diabetes

What does it all mean?

There is opportunity for:

- Improved care coordination and collaboration across specialty and non-specialty systems
- Improved health outcomes
- Efficiency in service delivery
- Cost savings
- Improving the capacity of all providers to utilize evidence-supported practices

Missouri Integrated Health Initiatives

Joseph Parks, M.D., Chief Clinical Officer – Missouri Dept. of Mental Health

SHOW - ME

Integration of Behavioral Health and Primary Care

My Background

- DMH Medical Director
- Consultant to MoHealthNet (Missouri Medicaid)
- President NASMHPD Medical Director's Council
- Practicing FQHC Psychiatrist
- Director Missouri Institute of Mental Health – University of Missouri St Louis

Overview: THE PROBLEM

- Increased morbidity and mortality associated with serious mental illness (SMI)
- Increased morbidity and mortality largely due to preventable medical conditions
  - Metabolic disorders, cardiovascular disease, diabetes mellitus
  - High prevalence of modifiable risk factors (obesity, smoking)
  - Epidemics within epidemics (eg, diabetes, obesity)
- Some psychiatric medications contribute to risk
- Established monitoring and treatment guidelines to lower risk are underutilized in SMI populations

Problem:

SMI and Reduced Use of Medical Services

- Less likely to be screened or treated for dyslipidemia, hyperglycemia, hypertension
- Less likely to receive angioplasty or CABG
- Less likely to receive drug therapies of proven benefit (thrombolytics, aspirin, beta-blockers, ACE inhibitors) post-myocardial infarction
- More likely to have premature mortality post-myocardial infarction

Newcomer J, Hennekens CH. *JAMA.* 2007;298:1794-1796.
Druss BG et al. *Arch Gen Psychiatry*. 2001;58:565-572.

Comparison of Metabolic Syndrome and Individual Criterion Prevalence in Fasting CATIE Subjects and Matched NHANES III Subjects

	Males			Females		
	CATIE N=509	NHANES N=509	*p*	CATIE N=180	NHANES N=180	*p*
Metabolic Syndrome Prevalence	36.0%	19.7%	.0001	51.6%	25.1%	.0001
Waist Circumference Criterion	35.5%	24.8%	.0001	76.3%	57.0%	.0001
Triglyceride Criterion	50.7%	32.1%	.0001	42.3%	19.6%	.0001
HDL Criterion	48.9%	31.9%	.0001	63.3%	36.3%	.0001
BP Criterion	47.2%	31.1%	.0001	46.9%	26.8%	.0001
Glucose Criterion	14.1%	14.2%	.9635	21.7%	11.2%	.0075

Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
McEvoy JP et al. *Schizophr Res*. 2005;80:19-32.

The CATIE Study

At baseline investigators found that:

- 88.0% of subjects who had dyslipidemia
- 62.4 % of subjects who had hypertension
- 30.2% of subjects who had diabetes
  WERE NOT RECEIVING TREATMENT

Nasrallah HA, et al. *Schizophr Res*. 2006;86:15-22.

“Mental Health” Care in Primary Care Settings

- Psychological distress drives primary care utilization
- Most somatic complaints don’t have an identifiable cause (Kroenke & Mangelsdorf, 1984)
- Only 30% of primary care visits are for an identified medical condition (Strosahl, 1998)
- More mental health interventions occur in primary care than in specialty mental health settings
- Behavioral health problems inflate medical costs and impede outcomes

The Problem

- Clinical Cost Drivers:
  - Untreated Medical Illness
  - Poor patient adherence to effective treatments
  - Medical Errors

- Administrative Cost Drivers:
  - Lack of coordination of care
  - Provider lack efficient HIT decision support systems
  - Fragmentation of systems of care

CMHC Mission

Recovery for Persons with SMI

CMHC Problem

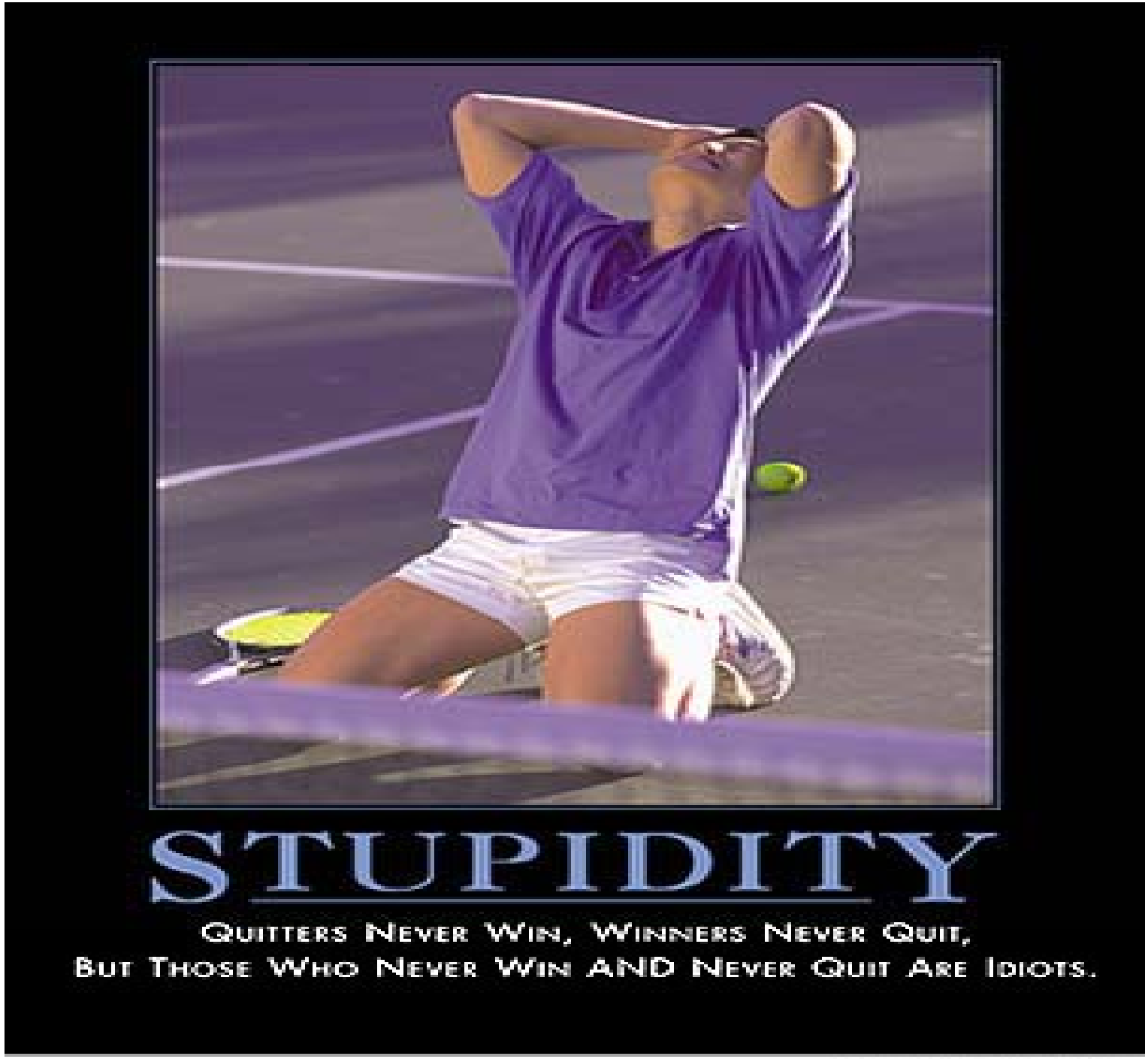
Early Death from Physical Illness Prevents Recovery from SMI

FQHC Mission

Healthy Patients including those with Mental Illness

FQHC Problem

Persons with Serious Mental Illness Die in their 50s of Chronic Treatable Medical Illness


STUPIDITY
Quitters Never Win, Winners Never Quit,
But Those Who Never Win AND Never Quit Are Idiots.
www.despair.com

Primary and Behavioral Health Care Integration Strategies in Search of a Model

- Preferential Referral Relationship
- Formalized Screening Procedures
- HIT Based Care Coordination
- Co-Location of Services
- Disease Management
- Behaviorist on Primary Care Team
- Health Care Home for Chronic Conditions

Integration Initiative

Recurrent Themes on the Path to Integration

- Building Relationships
- Communication
- Understanding the Model
- Physical Structure Modifications
- Hiring and Retaining the Right Staff
- State Paperwork Requirements Inhibit the BHC Model
- Billing Codes are not Conducive to Integration

Recommendations – Provide Information to Healthcare Providers

- HIPAA permits sharing information for coordination of care
- Nationally consent not necessary
- Exceptions:
  - HIV
  - Substance abuse treatment – not abuse itself
  - Stricter local laws

Progress to Date

- More Organizations are both CMHC and FQHC
  - One CMHC obtained new FQHC status
  - One merger of a CMHC with a FQHC
- Three FQHCs have chosen to contract with CMHCs for BH services at other sites beyond the grant rather than develop their own BH services
- Three CMHCs applying to become FQHCs
- Funding through Federal 330 Grant look-alike method leverages funding for uninsured by 30%

DMH NET

Missouri's CMHC Health Care Home Project

Principles

- Physical healthcare is a core service for persons with SMI
- MH systems have a primary responsibility to ensure:
  - Access to preventive healthcare
  - Management and integration of medical care

DMH NET – Strategy

- Health technology is utilized to support the service system.
- “Care Coordination” is best provided by a local community-based provider.
- Community Support Workers who are most familiar with the consumer provide care coordination at the local level.
- Nurse Liaisons working within each provider organization provide system support.
- Statewide coordination and training support the network of providers.

Recommendation – Medical Needs Have Same Priority as MH Needs

- Obtaining a “medical home” – a primary care provider responsible for overall coordination
- Medication adherence – just as important for non-MH meds
- Assisting in scheduling and keeping medical care appointments

Care Coordination
Integrates Healthcare Issues into CMHC Care Mechanisms

- Include healthcare goals in treatment plan
- Include healthy lifestyle goals in treatment plan
- Identify client's internal health care expert/champion
- Develop health and wellness services
- Provide nurse healthcare liaison – proven practice
- Verify healthcare services are occurring by utilizing data

Metabolic Syndrome Disease Registry

- Metabolic Syndrome
  - Blood pressure - weight
  - Cholesterol - height
  - Triglycerides - blood sugar
- Screening Required Annually since January 1
- Disease registry with results maintained on cyber access
- Next step – utilize data to identify care gaps

Initial Results

- Provide specific lists of CMHC clients with care gaps as identified by HEDIS indicators to CMHC primary care nurse liaisons quarterly
- Provide HEDIS indicator/disease state training on standard of care to CMHC MH case managers
- First quarter focus on indicator one-asthma substantially reduced percentage with care gap
  - Range 22% - 62% reduction
  - Median 45% reduction

A Typical Participant in This Overview

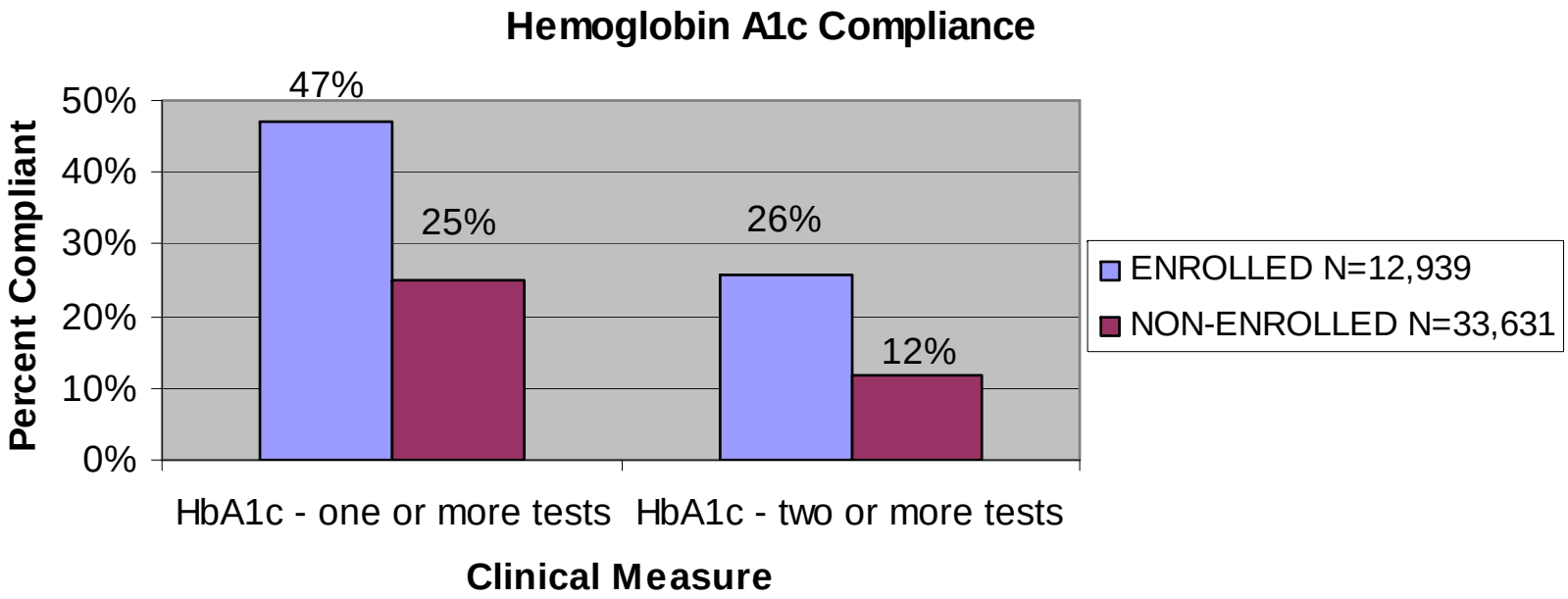
- A 47 year old male
- More than one major targeted disease
- Likely has a major cardiovascular diagnosis and diabetes
- Likely has experienced a major cardiac event
- A third have a major behavior health co-morbidity
- A generally motivated cohort

Continuously Enrolled 7/1/2007 - 6/30/2008
24,700

Disease	Number of Individuals	Percentage
Asthma	9,817	39.7%
CAD	16,982	68.8%
CHF	5,746	23.3%
COPD	8,155	33.0%
Diabetes	12,939	52.4%
GERD	12,592	51.0%
Sickle Cell	558	2.3%
Behavioral Disability	8,395	34.0%

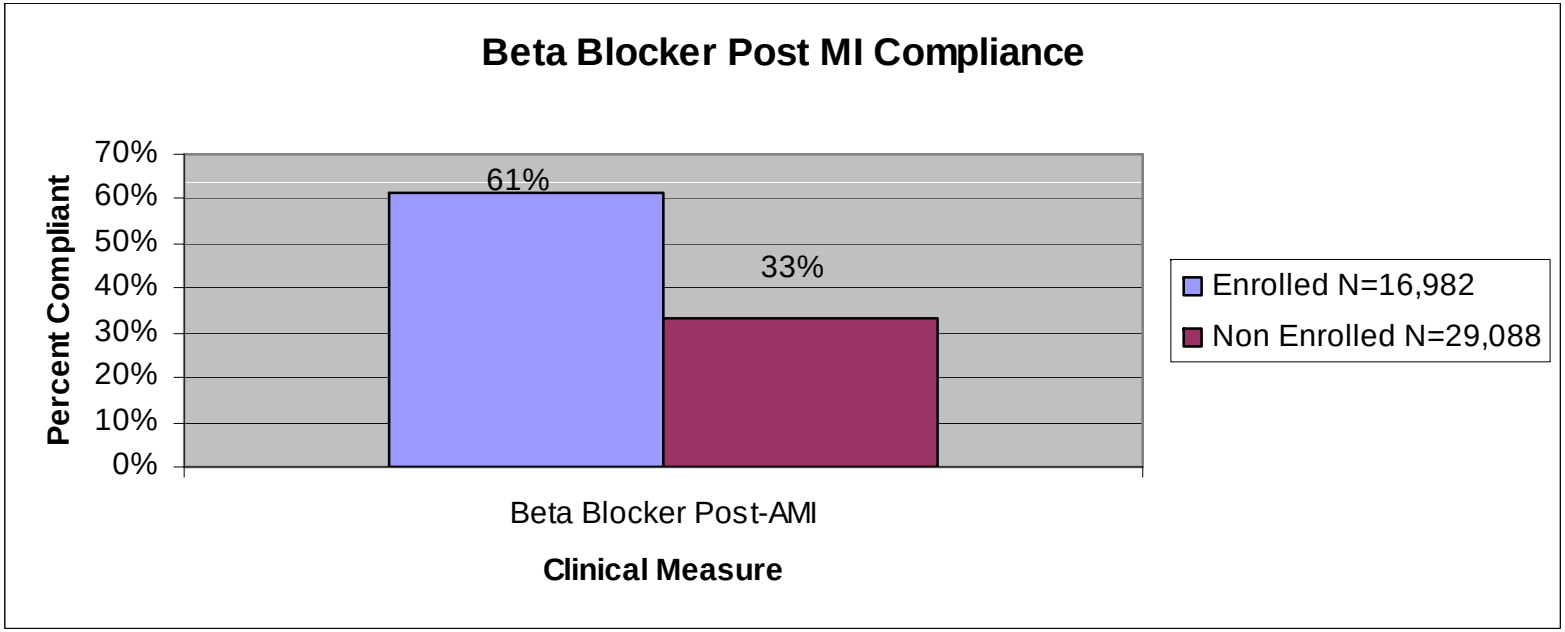
*Includes co-morbid conditions

Missouri CCIP Diabetes Outcomes



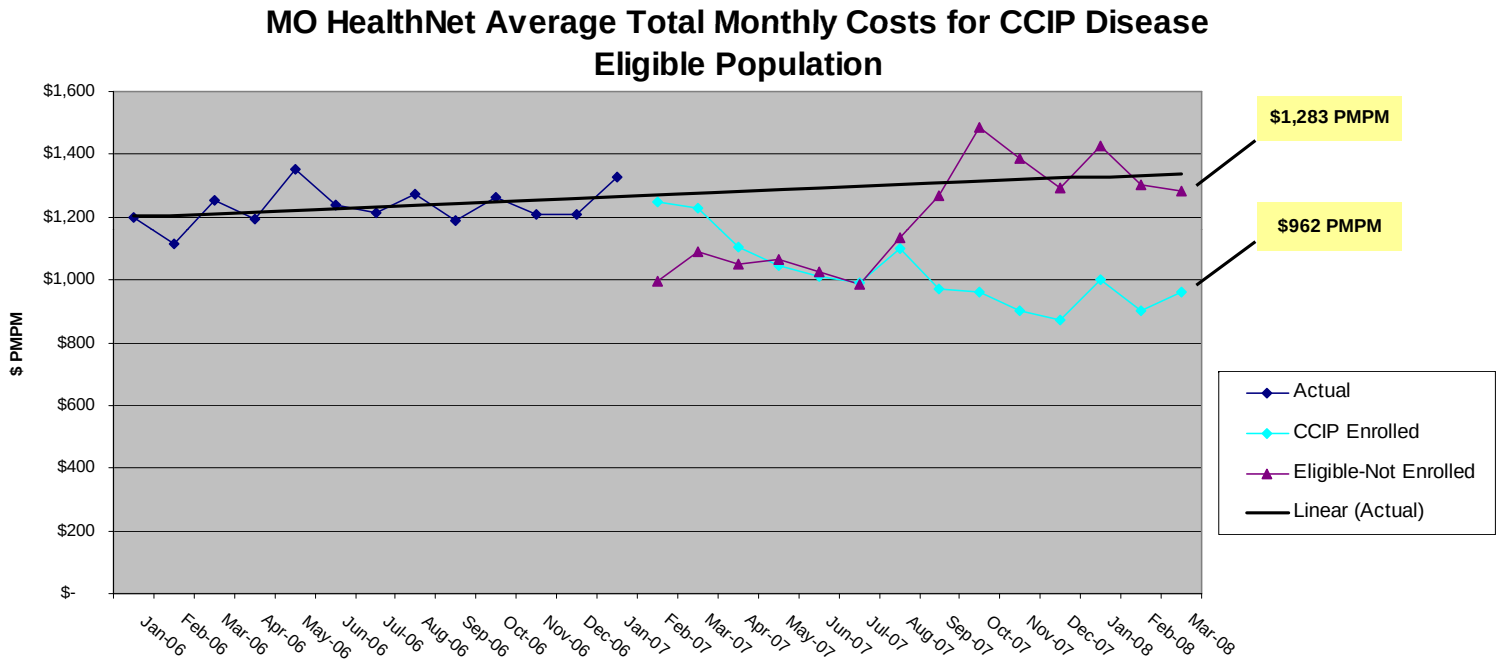
HbA1c testing provides an estimation of average blood glucose values in people with diabetes. Enrollees in the CCIP program received substantially more HbA1c testing than those not enrolled.

Missouri CCIP Coronary Artery Disease (CAD) Outcomes



CCIP enrollees with coronary artery disease (CAD) received recommended treatment with beta blocker medications at nearly twice the rate of non-enrollees.

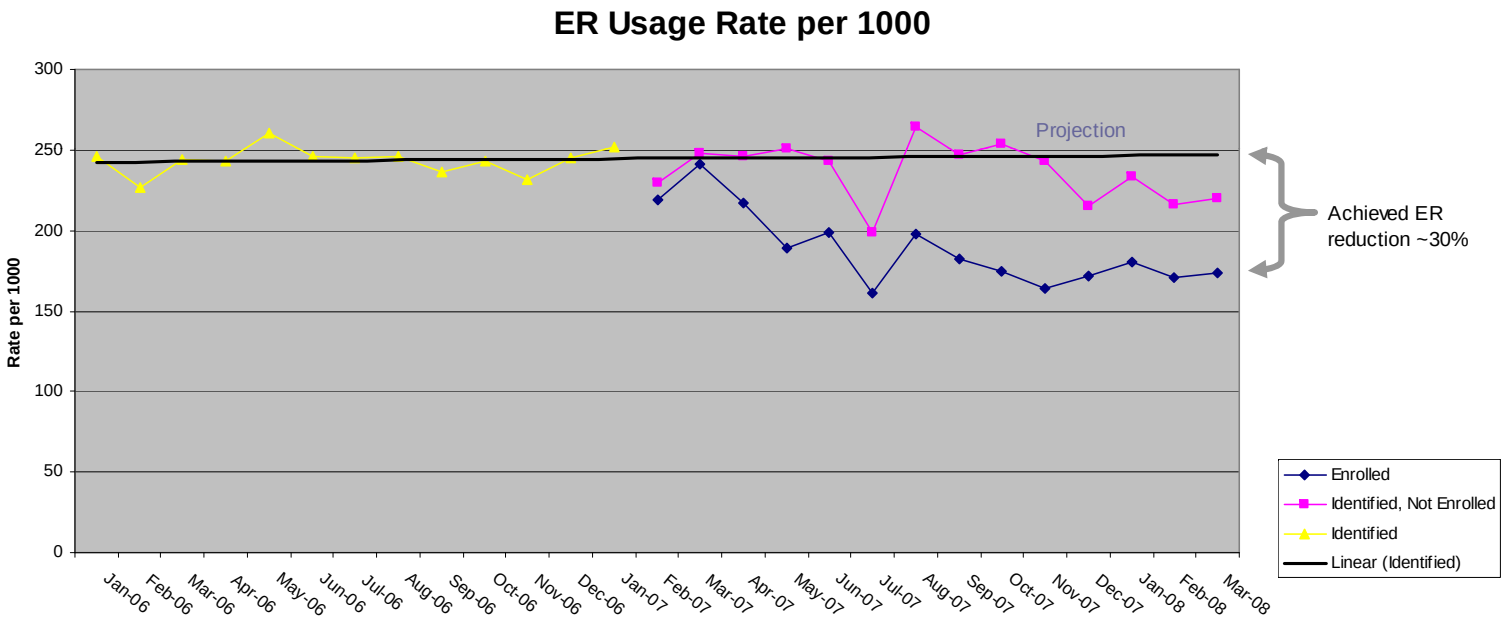
Trend Analysis of Total Costs



Average Total Monthly Costs for CCIP-enrolled participants were below projection.

March 2008 demonstrates a $321 PMPM savings.

Trend Analysis of Emergency Room Utilization



ER visits decreased more substantially than projected representing another key cost driver for savings

CMHC DISEASE MANAGEMENT

- Clients were Medicaid enrolled with a CCIP eligible medical diagnosis and a serious mental illness enrolled in a CMHC, but may or may not have been enrolled in CCIP.
- Clients received Psychiatric Rehabilitation services if they were eligible for those services.
- Average Medicaid annual medical cost for the clients was $18,672 per year.

Statewide Information

- Community Mental Health Centers have approved 10% of the healthcare home plans of care in the State Medicaid program.
- More than 35,000 patient histories have been reviewed in CyberAccess.
- More than 70% of patients have had a primary care visit within a 12-month period, according to claims; sampled chart review indicates a higher percentage (3 agency sample over 90%).
- Outcomes review of Missouri Psychiatric Rehabilitation programs indicates substantial off-trend cost savings for the overall healthcare cost after admission to the program.

Cost Savings achieved for clients in CMHCs

Base Period (CY2006)	$1,556
Expected Trend	16.67%
Expected Trend with no Intervention	$1,815.81
Actual PMPM in Performance Period (FY2007)	$1,504.34
Gross PMPM Cost Savings	$311.47
Lives	6,757
Gross Program Savings	$25,254,928
Vendor Fees	$0
Net Program Savings	$25,254,928
NET PMPM Program Savings	$311.47
Net Program Savings/(Cost) as percentage of Expected PMPM	17.15%

Medicaid Cost Savings for the 6,757 people

- OFF TREND SAVINGS OF $25 million annually.
- Actual Pharmacy services decreased by $9.2 million annually or 23%
- Actual General Hospital services decreased by $1.5 million or 6.8%
- Actual Primary Care services increased by $774,000 or 21%

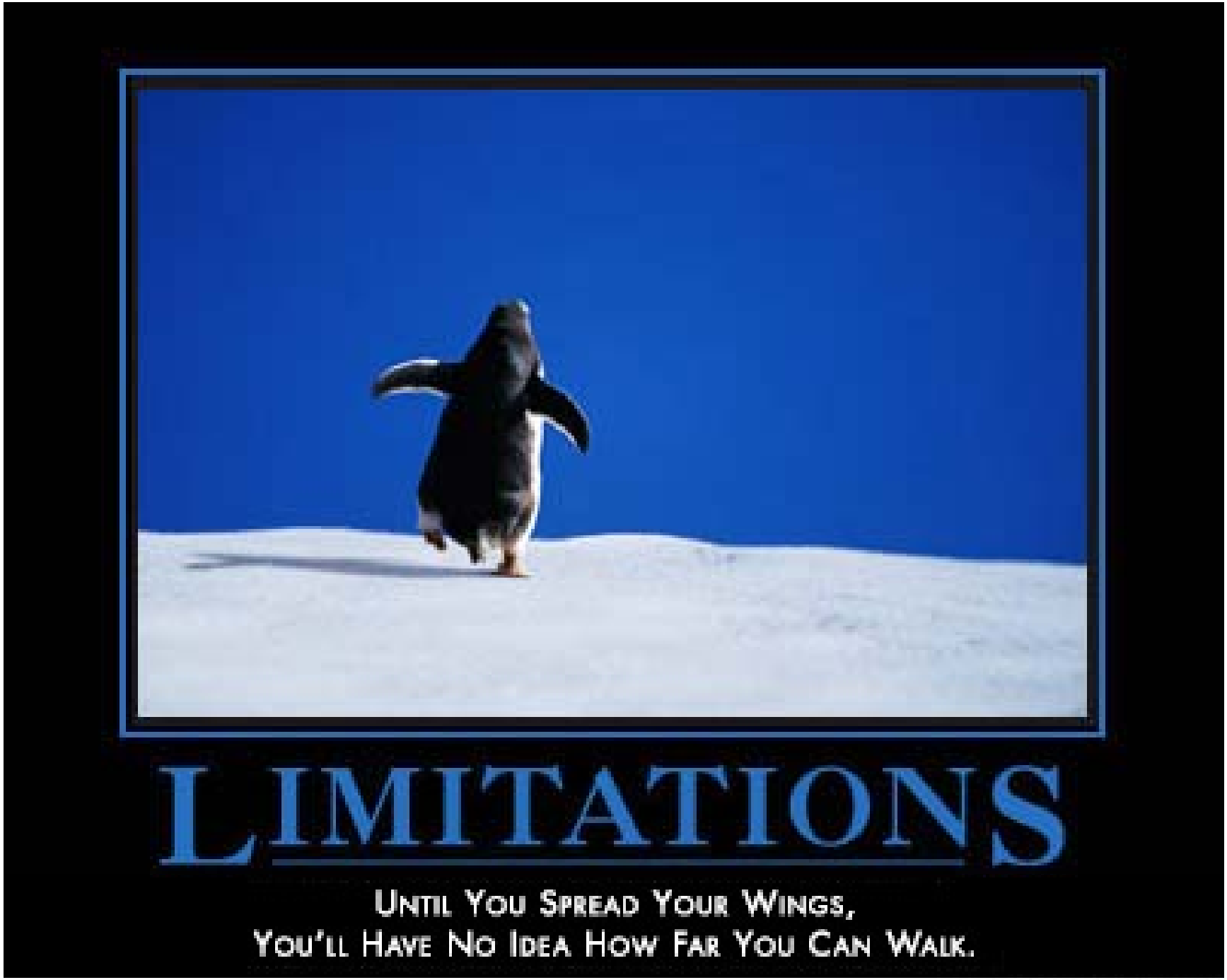
Goals: Lower Risk for CVD

- Blood cholesterol
  - 10% ↓ = 30% ↓ in CHD (200-180)
- High blood pressure (> 140 SBP or 90 DBP)
  - 4-6 mm Hg ↓ = 16% ↓ in CHD; 42% ↓ in stroke
- Cigarette smoking cessation
  - 50%-70% ↓ in CHD
- Maintenance of ideal body weight (BMI = 25)
  - 35%-55% ↓ in CHD
- Maintenance of active lifestyle (20-min walk daily)
  - 35%-55% ↓ in CHD

Hennekens CH. *Circulation.* 1998;97:1095-1102.

Strategies

- Incrementally build your organizations healthcare, competencies internally
- Build and maintain a collaborative partnership with a healthcare organization
- Merge/consolidate with a healthcare organization


LIMITATIONS
UNTIL YOU SPREAD YOUR WINGS,
YOU'LL HAVE NO IDEA HOW FAR YOU CAN WALK.
www.despair.com

Questions

Ohio Integrated Services Initiatives

- Community Support Services, Inc.
- Child Guidance & Family Solutions
- Center For Families and Children

The Margaret Clark Morgan Integrated Care Clinic at Community Support Services, Inc.

community SUPPORT services
www.cssbh.org
Celebrating Twenty Years

Program Description	Planning for an integrated care model began in 2007 in conjunction with the Summit County ADM Board, the Ohio Department of Mental Health, The Margaret Clark Morgan Foundation, The University of Akron College of Nursing, the Northeastern Ohio University Colleges of Medicine and Pharmacy and Klein's Pharmacy. The clinic and pharmacy opened in late 2008.
Population	Majority of clients served have Schizophrenia, Major depression, bi-polar disorder diagnoses. 50-60 percent of clients served have a mental illness and substance abuse dual disorder.
Intervention	Clinic provides integrated care for individuals without a "medical home." Also a training site for Advanced Practice Nurses, pharmacy students and, very soon, medical residents.
Impact	Roughly 600 individuals are enrolled in the clinic and receive treatment for hypertension, diabetes, and cancer. Enables closer coordination of care.

Child Guidance & Family Solutions

Program Description	Child Guidance & Family Solutions (CG&FS), serving the citizens of Summit County for more than 70 years.
Population	Provide comprehensive behavioral health care services to more than 4,000 children and counseling services to more than 500 adults annually.
Intervention	FIRST Program offers integrated services for individuals experiencing a first psychotic episode. Developed in partnership with BeST Center and Community Support Services (CSS), in operation out of CG&FS since January 2010.
Impact	Building & maintaining positive relationships with primary referral sources. To date, almost 30 individuals have been served: ▪ Three are in college ▪ Three are in high school ▪ Four are completing GEDs ▪ Four are employed ▪ Re-hospitalization rate is very low ▪ One client has already been transitioned to less intensive care

Center For Families and Children

Program Description	CFC is one of the largest nonprofit health and human service providers in Northeast Ohio, providing accredited and highly-acclaimed early learning, youth development, and behavioral health services since 1970.
Population	Behavioral health program serves more than 5,000 clients per year. 90% are adults with SMI; 10% are children and youth with significant to severe emotional disturbances.
Intervention	Address behavioral health complications and related early morbidity due to lack of access to **and** utilization of primary health care. (Health complications coupled with ability to travel, self motivation to access, or follow through on physical health care)
Impact	On-site contact among primary care and behavioral health providers is leading to efficiencies and more effective treatment.

Questions

Wrap Up

Ohio Medicaid SMI Research Project

- Lon Herman lherman@neoucom.edu
- Lorin Ranbom Lorin.Ranbom@osumc.edu
- Alicia D. Smith asmith@healthmanagement.com

Missouri Integration Initiatives

- Joseph Parks, M.D. Joe.Parks@dmh.mo.gov

BeST Center website:
http://www.neoucom.edu/bestcenter/

Office of Health Transformation website:
http://healthtransformation.ohio.gov/