The CMHC Value Proposition

How Our Dog Caught the Car
My Background

• Medical Director for National Council for Behavioral Health

• Previously
  • Missouri Medicaid Director – 3 years
  • DMH Medical Director – 20 years

• Practicing Psychiatrist -

• Distinguished Professor, Missouri Institute of Mental Health, University of Missouri –St. Louis

• Adjunct Professor of Psychiatry – University of Missouri Columbia
Where are we today? The good news

- There is growing awareness of our issues.
  - Understanding that behavioral health is essential to whole health
  - Sustained media attention, growing numbers of people talking openly about their or their loved one’s experience

- More Americans have coverage than ever before.
  - Coverage includes parity for most Americans
  - Full parity implementation has proven difficult, many consumers still lack access to key services
Good news: growing recognition that…

- Behavioral health is essential to whole health
  - Higher costs, poorer overall outcomes associated with co-occurring BH and physical health conditions

- Treatment works

- Recovery and a fully functioning life in the community are possible
Public Attention to Mental Health and Addiction is Growing

“Elsewhere, groups or networks have formed to spread the knowledge…They include the National Council on Behavioral Health’s Trauma-Informed Care Learning Community…”

Tryimg to make mental health first aid as familiar as CPR

Can treating past trauma lead to big US health savings?

Dan Mangan | @_DanMangan
Thursday, 21 Jan 2016 | 2:00 PM ET
More Americans gaining coverage (that includes parity)
Yet, lack of access, disparities persist

- Mental illness is the leading source of disease burden in the US
- Addiction has become a public health crisis
- Suicide rates are climbing
- Continued high levels of unmet need for care
- Little access to care even among working people with health coverage
- Lack of access to care has a critical impact on special populations: children, people of color, justice-involved
Addictions as chronic diseases ... medications ... inpatient ... residential and outpatient treatments ... and recovery supports including **housing**
Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case¹ and Angus Deaton¹

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround. The midlife mortality reversal was confined to white non-Hispanics; black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall. This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis. Although all the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Fig. 1 shows a cessation and reversal of the decline in midlife mortality for US white non-Hispanics after 1998. From 1978 to 1998, the mortality rate for US whites aged 45–54 fell by 2% per year on average, which matched the average rate of decline in the six countries shown, and the average over all other industrialized countries. After 1998, other rich countries’ mortality rates continued to decline by 2% a year. In contrast, US white non-Hispanic mortality rose by

http://www.pnas.org/content/112/49/15078.full
Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.
Mortality by Poising, Suicide, Chronic Liver Disease and Cirrhosis

Fig. 4. Mortality by poisoning, suicide, chronic liver disease, and cirrhosis, white non-Hispanics by 5-y age group.

“Deaths of Despair” among Middle-Class Whites

Midlife ‘Deaths Of Despair’ In The U.S., 2000 and 2014

Deaths by drugs, alcohol and suicide among non-Hispanic whites, ages 45-54

Life Expectancy


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

<table>
<thead>
<tr>
<th></th>
<th>CATIE</th>
<th>NHANES</th>
<th>p</th>
<th>CATIE</th>
<th>NHANES</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N=509</td>
<td>N=509</td>
<td></td>
<td>N=180</td>
<td>N=180</td>
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</tr>
<tr>
<td>Metabolic Syndrome Prevalence</td>
<td>36.0%</td>
<td>19.7%</td>
<td>.0001</td>
<td>51.6%</td>
<td>25.1%</td>
<td>.0001</td>
</tr>
<tr>
<td>Waist Circumference Criterion</td>
<td>35.5%</td>
<td>24.8%</td>
<td>.0001</td>
<td>76.3%</td>
<td>57.0%</td>
<td>.0001</td>
</tr>
<tr>
<td>Triglyceride Criterion</td>
<td>50.7%</td>
<td>32.1%</td>
<td>.0001</td>
<td>42.3%</td>
<td>19.6%</td>
<td>.0001</td>
</tr>
<tr>
<td>HDL Criterion</td>
<td>48.9%</td>
<td>31.9%</td>
<td>.0001</td>
<td>63.3%</td>
<td>36.3%</td>
<td>.0001</td>
</tr>
<tr>
<td>BP Criterion</td>
<td>47.2%</td>
<td>31.1%</td>
<td>.0001</td>
<td>46.9%</td>
<td>26.8%</td>
<td>.0001</td>
</tr>
<tr>
<td>Glucose Criterion</td>
<td>14.1%</td>
<td>14.2%</td>
<td>.9635</td>
<td>21.7%</td>
<td>11.2%</td>
<td>.0075</td>
</tr>
</tbody>
</table>

Meyer et al., Presented at APA annual meeting, May 21-26, 2005.
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.**
Causes of Excess Mortality

- Smoking
- Obesity
- Inactivity
- Polypharmacy
- Under diagnosis of medical conditions
- Inadequate treatment of medical conditions
Per Member Per Month Costs

- **Private Sector**:
  - No Mental Disorder: $250
  - Any Mental Disorder: $1,150

- **Medicare**:
  - No Mental Disorder: $600
  - Any Mental Disorder: $1,450

- **Medicaid**:
  - No Mental Disorder: $450
  - Any Mental Disorder: $1,200
MH/SU costs in NY State’s Medicaid Program

- MH Disorder
- SU Disorder
- No MH/SU Disorder

- Behavioral Health costs
- Physical Health costs
DOES THE BROADER HEALTHCARE INDUSTRY NEED BEHAVIORAL HEALTH TO SUCCEED?
Drivers of Increased Demand for Behavioral Health Care

- ACA Insurance reforms and Medicaid expansion substantially increases behavioral health coverage for adults

- ACA requires newly covered populations meet the parity requirements of Wellstone Domenici Parity Act

- Multiple parts of ACA require or incentivize integration of Behavioral Health and general medical care

- Stigma continues to drop releasing pent up demand

- In responding to recent press coverage of mass shootings increasing mental health services is more popular than gun control
New Drivers of BH Demand

• Medicaid Access Rule
  – Went into effect October 2016
  – Requires that MHD monitor and report on Access to 5 essential provider types – one is BH

• Medicaid Managed Care Rule
  – Extends Wellstone-Domenici BH parity to Medicaid Managed Care
  – Requires very detailed parity analysis for every eligibility group/benefit plan – approx. 100 in MO!

• Medicare MACRA P4P
Fact: Working people have little access to care

- Escalating deductibles/copays make treatment for mental illness (OCD, anxiety, depression - conditions highly responsive to medication and cognitive interventions) out of reach.

- Equally destructive are stagnant insurance reimbursement rates that make behavioral health cash only businesses.
Medicaid is Largely a BH Funding Program

- Single largest payer for BH services accounting for 26% of all behavioral health spending in 2009.
- The 20% of Medicaid beneficiaries with a BH diagnosis account for 48% of all Medicaid expenditures.
- Total Average Medicaid Expenditures
  - With BH diagnosis $13,303
  - Without BH diagnosis $3564
- About half of the non-dually eligible, under age 65 (including children) with disability have a behavioral health diagnosis.
- Total Medicaid expenditures for this group accounts for two thirds of total Medicaid spending.
Percent of Adult Group Covered by Medicaid, 2014

<table>
<thead>
<tr>
<th>Category</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>General adult population</td>
<td>12%</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>16%</td>
</tr>
<tr>
<td>Any mental illness</td>
<td>20%</td>
</tr>
<tr>
<td>Serious mental illness</td>
<td>24%</td>
</tr>
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Medicaid is radically different from commercial or Medicare coverage

• Targets high need populations left out of other insurance programs
• Negligible co-pays and no deductibles
• Coverage available nowhere else
  – Long term services and supports – NH, Personal care, Home health
  – Specialized support programs for specialized populations – SMI, DD, Foster care children, HIV,
  – Transportation to and from treatment
• Innovation
Innovative Medicaid programs For Behavioral Health Populations

• Community support services and case management
• Crisis Services and hotlines
• ACT Teams
• Peer Services
• ER diversion programs
• Partial Hospital
• Residential Treatment
• Psychosocial Rehabilitation
• CMHC Health Homes
• Family Support
### Problem Statement

**Exhibit 7: Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data**

<table>
<thead>
<tr>
<th>Diagnosis 1</th>
<th>Diagnosis 2</th>
<th>Frequency among all beneficiaries</th>
<th>Frequency among most expensive 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>Cardiovascular</td>
<td>24.5%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Central Nervous System</td>
<td>18.9%</td>
<td>39.8%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Pulmonary</td>
<td>12.5%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Central Nervous System</td>
<td>13.1%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Pulmonary</td>
<td>11.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Gastrointestinal</td>
<td>10.2%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>Pulmonary</td>
<td>7.0%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Renal</td>
<td>7.1%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Gastrointestinal</td>
<td>5.9%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Gastrointestinal</td>
<td>9.5%</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness.
- 52% of those who have both Medicare and Medicaid have a psychiatric illness.
Medicaid Spending Now Averages 26% of Total State Budgets

1985 - 2013

Total Medicaid Spending, as % of Total State Spending, Average across all states, And Missouri for 2014.

Source: HMA, based on NASBO, State Expenditure Report, 2014 and earlier years.
Total Spending on Medicaid and K–12 Education as % of Total State Spending

Average State Percentages, 2008 – 2014

Source: HMA, based on data in: NASBO, State Expenditure Report, 2014 and Earlier Years.
Big Trends

• Increased Coverage
• Increased Demand
• Focus of High Utilizers
• Increased desire for integration by payers
• Provider Consolidation
• Performance Based Payments
• Shrinking Psychiatric Workforce
Population Health Definitions

• The health of the population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services (Dunn and Hayes, 1999).

• A conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from it (Young, 2005).
Population-Based Care

• Don't rely solely on patients to know when they need care and what care to ask for and from whom - use data analytics for outreach to high need/utilizer patients

• Don't focus on fixing all care gaps one patient at a time - choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population

• The population-based health care provider is the public health agency for their clinic population
Data-Driven Care

• Patient Registries
• Risk Stratification
• Predictive Analytics
• Performance Benchmarking
• Data Sharing
Principles

- Use the data you have before collecting more
- Show as much data as you can to as many partners as you can as often as you can
  - Sunshine improves data quality
  - They may use it to make better decisions
  - It’s better to debate data than speculative anecdotes
- When showing data ask partners what they think it means
- Treat all criticisms that results are inaccurate or misleading as testable hypotheses
Most Important Principle

• Perfect is the enemy of good

• Use an incremental strategy

• If you try figure out a comprehensive plan first you will never get started

• Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity
Six Population Health Management Services

• Care Management

• Care Coordination

• Managing Transitions of Care

• Health Promotion

• Individual and Family Support

• Referral to Community Services
Comprehensive Care Management

• Identification and targeting of high-risk individuals
• Monitoring of health status and adherence
• Identification and targeting care gaps
• Individualized planning with the patient
Step 1 – Create Disease Registry

- Get Historic diagnosis from administrative claims

- Get clinical values from metabolic screening, clinical evaluation and management, care plans

- Combine into EHR Disease Registry
  - CMT’s PROACT
  - Azara’s DRV

- Online access available to all providers
Step 2 – Identify Care Gaps and ACT!

• Compare combined disease registry data to accepted clinical quality indicators

• Identify care gaps

• Sort patients groups with care gaps into agency specific to-do lists

• Nurse care manager helps team decide who will act

• Set up indicated visits and pass on info with request to treat
Important Provider Competencies

Characteristics:
- Outcomes-oriented
- Enabled by technology
- Patient-centered
- Use of data and analytics
- Performance transparency
- Ability to partner across organizations

Care Coordination

Care Management

Clinical Integration
What is a Health Home?

- Not just a Medicaid benefit
- Not just a program or a team
- It’s a system and an organizational transformation
Health Home
Target Populations

Primary Care Health Homes

- 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

CMHC Healthcare Homes

- 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
# Providers and Enrollment

<table>
<thead>
<tr>
<th>Primary Care Health Homes</th>
<th>CMHC Healthcare Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Providers</strong></td>
<td><strong>Providers</strong></td>
</tr>
<tr>
<td>• 21 FQHCs</td>
<td>• 26 CMHCs</td>
</tr>
<tr>
<td>• 61 Clinics</td>
<td>• 120 Clinics/Outreach offices</td>
</tr>
<tr>
<td>• 9 Hospitals</td>
<td>• Enrollment</td>
</tr>
<tr>
<td>• 36 clinics</td>
<td>• 20,877 adults</td>
</tr>
<tr>
<td>• 3 Independent Practices</td>
<td>• 3,359 children</td>
</tr>
<tr>
<td>• 3 Clinics</td>
<td>• 24,236 total</td>
</tr>
<tr>
<td><strong>Enrollment</strong></td>
<td></td>
</tr>
<tr>
<td>• 17,823 adults</td>
<td></td>
</tr>
<tr>
<td>• 1,168 children</td>
<td></td>
</tr>
<tr>
<td>• 18,991 total</td>
<td></td>
</tr>
</tbody>
</table>
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
Six CMS Required Health Home Functions

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

• “Paving the Way” – required for CEO to deliver

• Leadership and team “HCH 101”

• Access to Care – open access scheduling

• Population Health technology training (CMT’s PROACT)

• Physician Institutes

• NCQA and CARF
Facilitating Healthcare Kit

The FH kit contains 8 modules:

• Overview of Chronic Diseases and Risk Factors
• Issues Associated with Medication Non-Adherence
• Asthma and COPD: The Role of the Case Manager
• Hypertension in Clients with Mental Illness
• Diabetes and Mental Health
• Dyslipidemia and Mental Illness
• Obesity
• Smoking Cessation

All titles include:
- A 3-8 page Monograph
- A 35-40 minute lecture
- On-line post-test and CEU application online.

More info at: http://www.mimhtraining.com
More Training Initiatives

- Chronic illness and Disease Management
- Motivational Interviewing
- TEAMcare
- Wellness Coaching
- CARF
- Tobacco cessation
- Obesity interventions
CMHC Health Home Performance Progress

LDL, A1C, and Blood Pressure
All CMHC Health Homes have attained a completion rate above 80%!

N= 6,553
(at 3.5 years)

N= 20,648
(Dec 2015)
A1C Levels Over Time

About 7% had uncontrolled A1c levels

1 POINT DROP IN A1C

- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications
LDL Levels Over Time

About 45% had uncontrolled LDL levels

10% DROP IN LDL LEVEL

- 30% ↓ in cardiovascular disease
Blood Pressure Changes Over Time

20-24% had uncontrolled BP levels

CMHC-HHs

Baseline | Year 1 | Year 2 | Year 3
--- | --- | --- | ---
152.9 | 134.9 | 134.4 | 133.1
97.9 | 84.9 | 83.3

PCHHs

Baseline | Year 1 | Year 2 | Year 3
--- | --- | --- | ---
152.9 | 144.1 | 143.3 | 141.4
96.9 | 89.7 | 89.1 | 87.4

6 POINT DROP IN BLOOD PRESSURE

- 16% ↓ in CD
- 42% ↓ in stroke
Hospital Follow-up Jan 2012 through July 2014
DIABETES

Adults continuously enrolled
N= 1,889 (at 3.5 years)
N= 4,526 (Dec 2015)

Data source: CMT
HYPERTENSION & CARDIOVASCULAR DISEASE

- Adults continuously enrolled:
  - CVD N= 232 (at 3.5 years)
  - CVD N= 564 (Dec 2015)
  - HTN N= 2,401 (at 3.5 years)
  - HTN N= 6,111 (Dec 2015)

Data source: CMT
% OF CLIENTS WITH 1+ HOSPITALIZATION

Data source: MIMH

CMHC HCH Implementation January 1, 2012

First Year ↓ 9.1%
ER ENCOUNTERS

N= 17,084 (2011)
N= 18,776 (2012)
N= 19,103 (2013)
N= 20,345 (2014)

Data source: CMT
Cost Savings Year 1 (2012)

Health Homes have saved Missouri an estimated
$36.3 million
SAVINGS = $60 PMPM

Community Mental Health Center Healthcare Homes have saved Missouri
$31 million
SAVINGS = $98 PMPM

DM3700 subset saved
$22.8 million
SAVINGS = $395 PMPM
(4,800 lives)
CHANGE

When the Winds of Change Blow Hard Enough, the Most Trivial of Things can turn into Deadly Projectiles.
NASMHPD Technical Reports

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

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