



Utilizing the Community Mental Health System to Improve Indiana's Medicaid Delivery System

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ABD Taskforce
Family and Social Services Administration
State of Indiana

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Community Mental Health Centers in Indiana

Indiana's twenty-five (25) certified community mental health centers (CMHCs) provide statewide "safety-net" coverage for Indiana's most vulnerable citizens suffering from serious and persistent mental illness.

In FY 13, CMHCs in Indiana served over 65,000 behavioral health consumers suffering from serious mental health issues through the Medicaid Rehabilitation Option (MRO) program. In FY13, CMHCs expended over \$217.4 million in MRO funds by leveraging \$2 dollars in federal funds for every \$1 dollar in state and county funds (based on the current and approved FMAP).

CMHCs in Indiana have been instrumental in working with the Department of Child Services (DCS) to provide over \$22 million in MRO services for over 7,600 Hoosier children suffering from behavioral health conditions. We also are currently implementing a demonstration project related to at-risk CHINS 6 youth further assisting DCS with an important initiative.

Medicaid billing for MRO services is the primary funding mechanism in Indiana to ensure Seriously Mental Ill (SMI) adults and Severely Emotionally Disturbed (SED) children have access to critical behavioral health treatment. In addition, CMHCs provide Medicaid Clinic Option services, Medicaid behavioral health services through the Hoosier Healthwise and Care Select programs, community based funds from DMHA, and private insurance services.

Business Case for Change

49% of Medicaid beneficiaries with disabilities have a psychiatric illness. 52% of those who have both Medicare and Medicaid have a psychiatric illness.

People diagnosed with depression have nearly twice the annual health care costs of those without depression.

- The cost burden to employers for workers with depression is estimated at \$6,000 per depressed worker per year.
- Depression is one of the top 10 conditions driving medical costs, ranking 7th in a national survey of employers.
- Depression is the greatest cause of productivity loss among workers.

There is extensive evidence that individuals suffering from SMI and SED have a more difficult time securing and benefiting from primary health care services.

Extensive research suggests that suicide continues to be a serious public health issue as there is 1 suicide every 15 minutes in the United States.

Children and youth who are bullied are more likely to be depressed, have low self-esteem, lonely, anxious, as well as consider suicide.

Business Case for Change

About one in four adults suffers from a mental disorder in a given year.

Visits to emergency rooms involving the misuse of prescription drugs have doubled in the last five years.

On average, individuals with SMI die twenty-five (25) years earlier than the current life expectancy.

According to the United States Health Resources and Services Administration (HRSA), depression is the third leading reason an individual receives services in a community health center following diabetes and hypertension.

These concerning statistics demonstrate that real issues exist in the United States related to the treatment of behavioral health disorders. It is clear that barriers exist within the current health system framework to appropriately address these challenges.

Proposed Care Coordination Model

The ICCMHC firmly believes the community mental health centers system in Indiana can play a vital role in assisting FSSA in developing a risk-based managed care program that improves health outcomes and reduces the Medicaid cost curve.

The development of a risk-managed care program should seek excellence in care coordination as the optimal approach to achieve identified goals for individuals suffering from co-occurring chronic health disorders, including behavioral health.

The community mental health center system provides opportunities for early identification and intervention, counseling, guidance, care coordination, and chronic illness management.

Care coordination and health management should play a vital role in an individual's access to the delivery of health services.

For individuals suffering from co-occurring chronic health disorders, a care management approach is critically important as these health consumers are some of the highest utilizers of Medicaid services.

By utilizing non-traditional medical services an appropriately designed risk-managed care program allows for the funding of additional types supports to chronic health consumers that may not be a traditional "medical" intervention or associated with a currently approved CPT code, but utilize social determinant considerations (workforce, education, housing, transportation, family planning, and quality of life).

Proposed Care Coordination Model

A risk-managed care program should contain the ability to undertake consumer engagement activities to ensure care coordination is implemented based on the individualized treatment plan through appropriate linkages, referrals, non-traditional engagement, coordination and follow up to needed services and supports.

Risk-based managed care populations should include chronic health consumers who have a serious mental illness and who have or who also are at risk of developing another chronic illness.

Inclusion of these adults is focused on remediation of existing illness and prevention of new illnesses. Their inclusion also recognizes the impact that psychiatric medications have on physical status and the need to more responsibly manage prescriptions and the resulting physical impact of their use.

Through early prevention services, a well-developed risk-based managed program allows for preventative services to be incorporated into a care management program.

Proposed Care Coordination Model

A risk-based managed care program for children and adolescents with SED should contain prevention programs that will help inhibit the development of illnesses that might occur as they enter into adulthood, as well as to help reverse the development or slow the progression and extent of any existing illness (ie, obesity with a co-occurring SED).

Children and adolescents that have a SED frequently have faced trauma between the ages of 0-5 and research demonstrates that they are at much higher prevalence of physical illness than the general population.

A care management approach also needs to consider the involvement of the family or guardian in the treatment plan for the child.

Enhancing access to outpatient mental health services reduces psychiatric hospitalizations and significantly increases mental health care while controlling Medicaid utilization costs.

The ICCMHC is currently working independently, through on-going and regular meetings, with most managed care organizations in Indiana to improve our communication, dialogue, examine opportunities for improvements, and discuss best-practices.

Proposed Care Coordination Model

Under a risk-based managed care program some advantages may be created through better coordination of care and the delivery of more consistent quality services regardless of the payer source.

Contracted managed care companies **MUST** have the expertise for strong data analytics and an IT infrastructure that supports the exchange of critical consumer health data.

If developed properly under a risk-based managed care program, the care should be better coordinated within a network and services will not be duplicated or repetitive or prone to waste.

Currently, various managed care models exist in the United State with varying degrees of identified effectiveness.

Managed care programs often require the health provider to hire additional staff focused solely on carrying out the required administrative duties of the program which leads to reduced funding for direct health service delivery. FSSA should consider this issue when developing a risk-based managed care program.

Proposed Care Coordination Model

Managed care companies do not provide direct treatment to behavioral health consumers with SMI or SED and therefore care coordination activities under the current model have not appeared to be as effective as expected.

By working more effectively between managed care companies and direct services providers, such as the community mental health center system, improved coordination can occur through providers directly involved in treatment (and not solely undertaken through phone consultations, etc.)

The disadvantage of a risk-based program is that managed care decisions have the potential to put dollars ahead of patient care, rationing services based on financial rather than medical or behavioral health reasons.

Sustainability of a risk-based managed program should be considered in the development of the state's plan. Such an approach should consider the need for on-going payment streams without jeopardizing direct care for chronic health consumers. Often under managed care models, complicating and inconsistent rules and internal processes may limit health consumer services and create delays in service delivery.

Proposed Care Coordination Model

Utilizing currently CMS approved health homes as a care coordination model, the following are the types of conditions that a health consumer would meet for consideration into a risk-based managed care program:

A severe mental health condition, **AND (OR AT RISK OF DEVELOPING);**

One other chronic health condition such as; asthma, cardiovascular disease, diabetes, substance abuse disorder, pulmonary issues, developmental disabilities, overweight BMI>25

The development of a care coordination team should consider including a care coordination director who tracks enrollment, denials, discharges and transfers, coordinates management of HIT tools, develops memorandums of understanding (MOUs) with hospitals/FQHCs, and coordinates hospital admissions and discharges with appropriate hospital staff.

A well-developed risk- based managed care program should focus on promoting healthy lifestyles and preventive care and provide individual care for consumers.

Proposed Care Coordination Model

The care coordination team (CCT) would initially review client records and patient history, participate in annual treatment planning, including reviewing and signing off on health assessments , conduct face-to-face interviews with consumers to discuss health concerns and wellness and treatment goals , consult with primary care physicians about identified health conditions of their clients, coordinate care with external health care providers (pharmacies, PCPs, FQHCs, etc.), document individual client care and coordination in client records.

Under this proposed model, the CCT assures that enrolled health consumers receive consistent care, complying with appropriate medical standards, regular consults with the consumers psychiatrist, assists consumers in accessing primary care, ensuring medication adherence, assist with coordination of care with community and hospital medical providers, and maintains a monthly log of the consumer's progress towards improved outcomes.

By implementing these components under a risk-based managed care program, the State of Indiana is better positioned to established a Medicaid program that enhances the lives of chronically ill health consumers while preventing future Medicaid costs to the health care system.

Barriers to Effective Care Coordination

The ICCMHC believes that appropriate training and collaborative relationships between primary care providers and community mental health providers is not occurring at consistent levels due to complicating factors.

The management of the care for individual with chronic co-occurring health disorders should not be financially driven by short-term savings.

The payment structure under Medicaid “fee for service” does not work well for consumers with complex co-morbidities and does not allow non-traditional service providers and/or service interventions that support health care quality and the reduction of health care costs.

In some cases, integrated care is being utilized in Indiana, however funding barriers and restrictions on billing location have made a wide-spread application of this model challenging for both community mental health and primary health providers.

Barriers exist in current service definitions that further challenge the ability of health providers to effectively utilize treatment options that have been validated through evidence based practices.

Barriers to Effective Care Coordination

The current Accountable Care Organization (ACO) model has yet to fully embrace behavioral health as a vital component to its successful implementation in Indiana.

Approved ACOs in Indiana have not contracted or coordinated with community mental health providers in an effort to improve linkages and reduce current barriers as designed under the federal program (we have engaged in preliminary discussions with some ACOs however).

The current Medicaid enrollment process is complicated and time delayed. However, this may improve under presumptive eligibility.

Transportation, especially in rural areas, continues to be a major barrier to service delivery for individuals suffering from a disability.

Primary health providers, FQHCs, and managed care organizations do not fully understand what engagement and treatment entails for behavioral health consumers. Likewise, CMHCs need to better understand primary health.

SMI and SED consumers require a full array of services that meet continuum of care requirements as established under state law. Such services are extremely comprehensive and require on-going engagement.

Outcome and Performance Measures

There is a serious lack of service data available to community mental health providers (claims, pharmacy, real time hospitalizations, etc.) to identify high healthcare consumer utilization which is contributing to extensive service utilization and associated with poor quality health outcomes.

The information technology infrastructure in Indiana is lacking which impacts the ability to provide effective care coordination and management.

FSSA should consider the utilization of National Outcome Measures (NOMs) for behavioral health services as a part of the Medicaid managed care program.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) established NOMS in an effort to develop a reporting system that will create an accurate and current national picture of substance abuse and mental health services.

Ten domains were identified in order to establish consistent outcomes to measure. The NOMs that were defined include areas such as; abstinence from drugs or alcohol, employment/education, access/capacity, criminal justice, housing, retention, social connectedness, perception of care, cost effective, and the use of evidence-based practices.

Outcome and Performance Measures

Quality outcome measures for SED and SMI consumers has been challenging due to the lack of consistent measures that have been agreed to by governmental funding entities, behavioral health providers, primary health providers, and behavioral health consumers.

Currently, managed care companies involved in the Care Select program utilize HEDIS measures for the determination of effectiveness outcomes for behavioral health consumers enrolled in approved programs. While HEDIS measures are a valuable tool, they do not fully determine true outcome and performance measures for behavioral health consumers (ie, social determinants).

Outcome measures should appropriately examine clinical outcomes that consider schizophrenia and the other co-occurring chronic health disorder such as diabetes, hypertension, and obesity.

Experience of care will assist in determining the satisfaction of a health consumer in the care they have received.

The quality of care should also be considered when determining outcome measurements. Such an approach will assist in determining if care coordination efforts are effective in reducing clinical conditions.

Outcome and Performance Measures

Indiana should strive to develop a more effective technology infrastructure that is focused on the importance of critical consumer health data.

Developing outcome based measures requires the ability to establish a baseline for the health consumer in a way that is agreed to by the State, health provider, and consumer.

Using a consumer health baseline, the ability to manage and oversee the care for an individual with co-occurring health disorders is better understood by all parties involved in the person's treatment. Outcomes are then properly measured under such a model with an agreement between impacted parties on expectations.

Barriers exist in the current Medicaid reimbursement for inpatient coverage provided by an Advanced Practice Nurse (APN) which further limit the ability to extend limited resources further without sacrificing the quality of care.

Additional barriers include enrollment into Medicaid and the need to allow for home-based assessments to be reimbursed.

Finally, in a traditional clinic setting, credentials to provide counseling services should be the same across all disciplines.

Outcome and Performance Measures

Quality outcomes should be value-based and look at overall costs and services compared to health improvement outcomes. Outcomes should represent community based services and care management, prevention, compliance, and the reduction of intensive and costly service such as hospitalizations and inappropriate emergency room utilization.

Outcomes should represent community based services and care management, prevention, compliance, and the reduction of intensive and costly service such as hospitalizations and inappropriate emergency room utilization.

A risk based managed care program should provide specific lists of CMHC consumers with care gaps as identified by HEIDIS indicators to the CMHC care coordination team.

The state should financially support implementing HEIDIS indicator/disease training on standards of care to community mental health center staff engaged in care coordination activities.

HIPAA permits the sharing information for coordination of care. Consumer consent is not necessary under a care coordination model as long as appropriate safeguards are in place to address health consumer confidentiality.

Exclusions from Risk-based Managed Care

The ICCMHC believes that individuals who have a SMI or SED and are eligible to receive treatment under the current MRO program should be excluded from the risk-based managed care program even though they may have a disability determination. However, SMI and SED consumers could participate in a care coordination model that involves a per member per month (PMPM) payment structure that is not based on a fee for service model.

MRO consumers often need on-going rehabilitation or habilitation services. The health needs for these populations are frequent and highly specialized and the community mental health system serves them well under the current MRO model administered by the Division of Mental Health and Addiction (DMHA).

DMHA and the Office of Medicaid Planning and Policy (OMPP) recently submitted a State Plan Amendment (SPA) for a 1915(i) program related to the behavioral health habilitation needs of specific qualifying adults, as well as an enhanced wrap-around service program in the treatment of children suffering from behavioral health disorders.

It is the belief of the ICCMHC that these programs are critically important to the behavioral health needs of SMI and SED consumers and should not be included under a risk-based managed care program even though certain individuals under the MRO and 1915(i) programs may have a disability determination.

Exclusions from Risk-based Managed Care

The MRO program in Indiana continues to be a highly effective approach to providing behavioral health services for adults suffering from SED and SMI.

The MRO program was dramatically modified by FSSA in 2010 in an effort to improve the integrity of the program while focusing on a recovery model for SMI or SED health consumers.

The revised MRO program ensures that service unit utilization is managed through a prior-authorization process.

The ICCMHC believes that individuals currently or in future need of MRO services and who meet eligibility criteria, regardless if they have a disability determination or not, continue to be served under the MRO program.

Such an approach will ensure that these individuals receive a complete continuum of care as established in Indiana both legislatively and in administrative code.

Finally, the MRO program utilizes a unique federal medical assistance percentage (FMAP) approach that has assisted the State in containing Medicaid state match requirements by utilizing the community mental health centers state funding allocation.

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Questions??



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