THE IMPACT OF INTEGRATED HEALTH HOMES ON MENTAL HEALTH SERVICE DELIVERY

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Carole Matyas, MSW

Position: Vice President of Behavioral Health Operations, WellCare Health Plan. Ms. Matyas oversees enterprise wide behavioral health operations for the company, to assure that WellCare develops a fully integrated medical/behavioral program centered in whole person attention and care. Carole has more than 30 years of behavioral health-related experience, with 15 of those years of experience in health plan operations at WellCare (since 2011), Magellan, Schaller Anderson (A Medicaid managed care organization), and Value Options. Carole spent her early career as a licensed social worker providing direct clinical services in a group practice, community mental health and a residential treatment center. In February 2013, Carole was appointed to serve on the Board of Directors for Drug Abuse Comprehensive Coordinating Office, Inc. (DACCO) in Tampa, Fl. Carole has been the recipient of awards from Mental Health America and NAMI for her dedication to mental health advocacy.

Education: Ms. Matyas earned both her undergraduate and Master of Social Work degrees from Marywood University in Scranton, Pennsylvania.

Katie Arjes, MS, LBSW, CADC

Position: Director for Black Hawk Grundy Mental Health Center’s Integrated Health Home (IHH) program. Katie has worked for Black Hawk Grundy Mental Health Center with the IHH program since the program began in April 2014. She has helped implement a team-based patient-centered approach to empowering members to reach their whole health and wellness goals. Katie has worked in the mental health or substance abuse field for 15 years with both adults and adolescents. She has also been trained as a psychiatric rehabilitation practitioner.

Education: Ms. Arjes received her Master’s in Rehabilitation Counseling from Drake University and earned a Bachelor’s degree in Social Work from the University of Northern Iowa.
This program is paid for by Otsuka Pharmaceutical Development & Commercialization, Inc.; and Lundbeck, LLC.
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Objectives

• To understand the integrated Medicaid health home model
• To explore what payers are looking for in integrated Medicaid health home arrangements
• To discuss how providers are meeting the expectations of payers and consumers under integrated Medicaid health home arrangements
What Is An Integrated Medicaid Health Home?

A Framework For Care Coordination¹

5% of U.S. population accounts for half (49%) of health care spending – concentrated in chronic comorbid health conditions

Core Health Home Requirements

Challenges & Successes Implementing Our Integrated Health Home
Black Hawk-Grundy Mental Health Center

We offer the following core services:

– Outpatient Services
– Evaluation Services
– School-based Counseling
– Emergency Services
– Consultation and Education
– Community Support & Homeless Program
– Peer Support
– Integrated Health Home

1. Partnering With Your Care In Mind (2016), UnityPoint- Health - Blackhawk-Grundy Mental Health Center Overview.
Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
An Integrated Health Home (IHH) is a team of professionals working together to provide care coordination for both medical and behavioral health services using a patient-centered, team-based approach focused on improving the client’s overall well-being.¹

**Team members:**¹

- Nurse Care Manager  
- Care Coordinator  
- Peer Support Specialist  
- Family Support Specialist on pediatric team

¹. Partnering With Your Care In Mind (2016), UnityPoint- Health - Blackhawk-Grundy Mental Health Center Overview.  
Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Who Is Eligible To Enroll?

- Enrolled in Medicaid
- An adult with a Serious Mental Illness (SMI)
  - Psychotic Disorder
  - Schizophrenia
  - Schizoaffective Disorder
  - Bipolar Disorder
  - Major Depression
  - Delusional Disorder
  - Obsessive-compulsive Disorder
- Children and youth with a Serious Emotional Disturbance (SED)
  - Including a diagnosable mental, behavioral or emotional disorder that results in impairment in everyday functioning.

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Care Coordination

- Conduct individualized, comprehensive whole person assessment
- Scheduling appointments
- Making referrals
- Tracking referrals and appointments
- Follow-up monitoring
- Communicating with providers on interventions and goals
- Conducting joint treatment staffings
- Support coordination of care with primary care providers and specialists

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Capitation Model Of Reimbursement

- Start up funding based on attribution list
- PMPM for each enrolled adult and child
- Intensive Care Management Members
- Initial Quarterly Incentives
  - 7 day follow up appointments
  - BMI
  - Annual PCP and Dental visit
  - All cause readmissions
  - HWQ and QCS
  - A1C within last 6 months > 8
  - Member experience survey
- Changes with Managed Care

PMPM – Per Member Per Month; BMI – Body Mass Index; PCP – Primary Care Physician; HWQ - Health & Wellness Questionnaire; QCS - Quality Compliance Systems; A1c – Glucose Screening Test For Diabetes

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge: #1

• Due to co-morbidity Medical Health Homes were trying to enroll the same patients as IHH.

Solution

• Joint meeting to build relationships to increase collaboration. Desire to be partners versus competitors.

IHH – Integrated Health Home

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge #2

- Initial decrease in projected start up funding. One-fourth of our attribution list was enrolled in a MHH or the Iowa Wellness Plan, making them not immediately available to be enrolled in IHH.

Solution

- Partnered with MHH to determine which Home was the best fit. Converted over 100 patients to the State Medicaid Plan with the Medically Exempt form.

MHH – Medical Health Home; IHH – Integrated Health Home
Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge #3

• By 4th month, payment was based only on those enrolled - PMPM. Initial focus was on enrollment, requiring help from everyone internally.

Solution

• Trained non IHH staff to complete enrollment paperwork, provided talking points, easy to understand brochure, and an incentive to enroll.

PMPM – Per Member Per Month; IHH – Integrated Health Home

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge #4

- Community buy-in for external referrals.

Solution

- Started a quarterly Stakeholder meeting
- MOUs
- Joint referral form to be used for any IHH
- Community presentations and marketing efforts

MOU – Memorandum Of Understanding; IHH – Integrated Health Home
Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge #5

- Lots of hard work for IHH team, including meeting quarterly performance measures.

Solution

- Participative management style to empower team
- Strategic planning and monthly goals
- Providing opportunities to learn and grow
- Celebrate successes

IHH – Integrated Health Home
Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge #6

• Change in expectations for health home services.

Solution

• Developing of new processes.
• Increase in contacts to members.

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Challenge #7

Medicaid Modernization

- Multiple MCOs
- 5 payers
  * 3 MCOs
  * State
  * Region
- Different authorization and reimbursement processes
- New systems and processes

Solutions?

MCOs – Managed Care Organizations

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Benefit To Client & Families

• Shared care plan between medical and behavioral health clinicians – allows us to treat the client – mind, body and spirit
• Reduced red tape, better communication and easier access to care
• Help navigating the healthcare system and advocacy to ensure all needs are met
• Support Services and referrals to community resources
• 24-7 accessibility emergency care

Source: Internal data from UnityPoint Health - Blackhawk-Grundy Mental Health Center, Waterloo, Iowa.
Agenda

- Background
- WellCare Roles
- Enrollment
- Population and Market Characteristics
- Staffing
- Care Management and Clinical Outcomes
- Financial Management
- Sample Reports
- Implications

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Background

The WellCare Enterprise Core model is based on the Missouri CMHC Healthcare Home program which became operational on January 1, 2012.

| Within 18 months their enrollment grew from 15,815 to 18,408<sup>1</sup> | They demonstrated consistent improvement in DM quality measures<sup>1</sup> | Reduced hospital admission rates by 12.8%<sup>1</sup> | Reduced emergency room rates by 8.2%<sup>1</sup> |

CMHC – Community Mental Health Center; DM – Disease Management


Source: Internal data from WellCare Health Plans, Tampa, Florida.
WellCare Roles

- Assess readiness for BHH
- Assist potential BHH providers with information regarding resources to develop capabilities
- Contract for BHH services
- Provide reports to BHHs
- Monitor and report quality measures and care gaps

BHH – Behavioral Health Home

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Enrollment

Initial Assignment

• Medicaid and Dual Eligibles with:
  – At least $5,000 in total claims in prior 12 months, and
  – One or more visits (claims) from a CMHC in the prior 12 months
  – Of any age

CMHC – Community Mental Health Center
Source: Internal data from WellCare Health Plans, Tampa, Florida.
Enrollment

Initial Assignment (Cont.)

- SMI, SED, or SUD and at least one of the following chronic conditions:
  - Diabetes
  - COPD
  - Asthma
  - Cardiovascular Disease (HTN, CHF)
  - BMI>25
  - Developmental Disability

- Members are assigned by WellCare to the last CMHC with a claim in the system

SMI – Serious Mental Illness; SED – Seriously Emotionally Disturbed; SUD – Substance Use Disorder; COPD – Chronic Obstructive Pulmonary Disease; HTN-hypertension; CHF - Congestive Heart Failure; BMI – Body Mass Index; CMHC – Community Mental Health Center

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Enrollment

- CMHCs have 3 months to outreach and engage their assigned members
- Members are excluded if any of the following are present:
  - No longer eligible for Medicaid
  - In a Medicaid status inconsistent with enrollment in a health home (e.g. institutionalized)
  - Members who opt-out or whose guardians opt-out
  - Medicare only (non-duals)

CMHCs – Community Mental Health Centers

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Enrollment: Ongoing

- On a quarterly basis, WellCare will review claims for members with a BH diagnosis and at least $5,000 in costs in prior 12 months who have not received outpatient BH services.
- Based on geo-access, each CMHC will receive a list of the non-engaged members and attempt to engage in the program.

BH – Behavioral Health; CMHCs – Community Mental Health Centers
Source: Internal data from WellCare Health Plans, Tampa, Florida.
Population Characteristics

- Individuals with SMI are prone to many different physical health problems. While these diseases are also prevalent in the general population, their impact on individuals with SMI is significantly greater.¹
  - A nationwide, population-based study found schizophrenia to be associated with a 1.37 times greater risk of acute respiratory failure and a 1.34-fold greater risk of mechanical ventilation¹
  - Prevalence of diabetes in people with schizophrenia is 2 - 3 times higher than the general population²
  - People with IDD are 3 to 6 times more likely to have SMI than the general population³

- In addition to a higher prevalence of chronic conditions, this population often has more deficiencies in the social determinants of health⁴

SMI – Serious Mental Illness; IDD – Intellectual Disability Disorder

Market Characteristics

The Enterprise Core Model is being launched in three states as a “voluntary” program, and one state as a “mandatory” program, targeting the top 5 CMHCs by member volume based on qualifying criteria.

<table>
<thead>
<tr>
<th>BHH--Voluntary</th>
<th>BHH--Mandatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida Medicaid</td>
<td>Georgia Medicaid</td>
</tr>
<tr>
<td>Kentucky Medicaid</td>
<td></td>
</tr>
<tr>
<td>New Jersey Medicaid</td>
<td></td>
</tr>
</tbody>
</table>

CMHCs – Community Mental Health Centers; BHH – Behavioral Health Home
Source: Internal data from WellCare Health Plans, Tampa, Florida.

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Market Characteristics

Whether the Behavioral Health Home is required by contract or not, a goal of the WellCare Enterprise Core model is to align the markets around the following:

- BHH Contract Amendment
- BHH Performance Standards and Accountability
- BHH Candidate Assessment Survey
- MCO Staffing to support the program

BHH – Behavioral Health Home; MCO – Managed Care Organization

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Behavioral Health Home Staffing

- In order to function as a BHH there are additional tasks and therefore staffing implications
- Key staff required to operate as a BHH include:
  - A BHH administrator, accountable for the overall operation of the program
  - Clerical administrator for data management
  - Care managers who work to manage the care coordination of enrolled members
  - A primary care clinician who is either on site or readily available for consultation

BHH – Behavioral Health Home
Source: Internal data from WellCare Health Plans, Tampa, Florida.
BHH Clinical Staffing Ratios

To ensure there is adequate staff to manage the enrolled members, the following staffing ratios are recommended

– Care managers at caseload of 200-250 members
– Nurse Care Supervisor for every 5 care managers (team of 200-250 members)
– Primary Care clinician able to contribute 1 hour per year to each enrolled member

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Readiness Survey To Serve As A BHH

Each Behavioral Health Home enrollee must have an ongoing relationship with a Behavioral Health provider trained to provide first contact, continuous, and comprehensive care.

- Provide a list of all staff that support the BHH functions and their roles.
- What are your staffing ratios for those roles?

Whole Person Orientation

- Provide evidence of such (company materials, policies, procedures).
- How will you ensure access and coordination with medical services?

Enhanced Access

- How will you provide 24/7 access to routine and urgent care - either onsite at the BH-PCMH or through collaborative partnerships with other primary care and urgent care providers?
- BHHs must have robust after-hours care plans which describe how enrollees will be connected to after-hours providers and receive transportation services if necessary. How will you ensure this?

BHH – Behavioral Health Home; BH-PCMH – Behavioral Health Patient Centered Medical Home; EMR – Electronic Medical Record; HIE – Health Information Exchange
Source: Internal data from WellCare Health Plans, Tampa, Florida.
Readiness Survey To Serve As A BHH, Continued

Coordinated and/or Integrated Care
• Describe your disease registries, EMR, information technology, HIE or other means to assure that enrollees receive the indicated care when and where they need it in a culturally and linguistically appropriate manner.
• Describe your processes that support the proper selection of steps along the referral continuum and assist enrollees in making sense of tests, diagnoses, and recommended procedures, treatments, and therapies?

Quality and Safety
• What programs do you have in place that demonstrate attention to quality and safety for the patients your serve?
• Do have currently engage in quality improvement programs? If so, please describe.
• What was your score on the last WellCare chart audits? (If a current provider)

BHH – Behavioral Health Home; BH-PCMH – Behavioral Health Patient Centered Medical Home; EMR – Electronic Medical Record; HIE – Health Information Exchange
Source: Internal data from WellCare Health Plans, Tampa, Florida.
Care Management

**Behavioral Pharmacy Management**
- Adherence to quality indicators (e.g. psychotropic medications in children)

**Medication Adherence**
- Both psychotropic medications and medications for cardiac, hypertension, asthma and COPD

**Disease Management**
- BP control in hypertension
- Lipid control for cardiac patients
- Diabetes (control BP, A1C, LDL)
- Metabolic Screening
- BMI control
- Tobacco Use

COPD – Chronic Obstructive Pulmonary Disease; BP – Blood Pressure; A1c – Glucose Test for Diabetes; LDL – Low Density Lipoprotein; BMI – Body Mass Index
Source: Internal data from WellCare Health Plans, Tampa, Florida.
Care Management, Continued

- Participation in psychiatric hospital discharge planning
  - Member seen within 7 days of hospital discharge
  - Medication reconciliation within 7 days of hospital discharge

- Ensure members have annual visit with PCP

- Ensure members have appropriate lab studies for their conditions

COPD – Chronic Obstructive Pulmonary Disease; BP – Blood Pressure; A1c – Glucose Test for Diabetes; LDL - Low Density Lipoprotein; BMI – Body Mass Index

Source: Internal data from WellCare Health Plans, Tampa, Florida.
Behavioral Health Home Performance

As part of the Enterprise Model Behavioral Health Program, earnings will be based on achieving specific performance levels or benchmarks:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-Day Follow-Up - Mental Health (FUH)</td>
<td>Meets HEDIS 50th Percentile</td>
</tr>
<tr>
<td>Emergency Department (ED) Utilization</td>
<td>&lt; 55/1000 member months (Children)</td>
</tr>
<tr>
<td></td>
<td>&lt; 170/1000 member months (Adults)</td>
</tr>
<tr>
<td>LDL testing for persons with cardiovascular disease and schizophrenia</td>
<td>Meets HEDIS 50th Percentile</td>
</tr>
<tr>
<td>SMC15 (SMC15)</td>
<td></td>
</tr>
<tr>
<td>Follow-Up Care for Children Prescribed ADHD Medication- (ADD-Children)</td>
<td>Meets HEDIS 50th Percentile</td>
</tr>
<tr>
<td>(ADD)</td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Management- (AMM)</td>
<td>Meets HEDIS 50th Percentile</td>
</tr>
<tr>
<td>Medication Management for People With Asthma (MMA)</td>
<td>Meets HEDIS 50th Percentile</td>
</tr>
</tbody>
</table>

2. Source: Internal data from WellCare Health Plans, Tampa, Florida.

HEDIS – Healthcare Effectiveness Data Information Set; SMC15 – Serious Mental Condition; ADD - Attention Deficit Disorder
Behavioral Health Home Performance, (Continued)

As part of the Enterprise Model Behavioral Health Program, earnings will be based on achieving specific performance levels or benchmarks:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (CDC)(^2)</td>
<td>Most recent HbA1c level less than 7.0%(^2)</td>
</tr>
<tr>
<td>Smoking Cessation(^2)</td>
<td>Screened for tobacco use &amp; received cessation intervention, counseling, &amp;/or pharmacotherapy(^2)</td>
</tr>
<tr>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (^1)</td>
<td>Meets HEDIS 50th Percentile(^2)</td>
</tr>
<tr>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) (^1)</td>
<td>Meets HEDIS 50th Percentile(^2)</td>
</tr>
<tr>
<td>Body Mass Index(^2)</td>
<td>BMI documented(^2)</td>
</tr>
</tbody>
</table>

HEDIS – Healthcare Effectiveness Data Information Set; SSD – Serious Mental Condition; APM - Antipsychotic Monitoring; BMI – Body Mass Index

2. Source: Internal data from WellCare Health Plans, Tampa, Florida.
Financial Management

- The funding of a health home PMPM is designed to support three key enhancements for their enrollees:
  - Improved care management and reporting
  - Targeted training and technical assistance for their staff and IT systems
  - Additional staffing for care coordination
- Funding also requires evidence that the BHH services are occurring and that adequate staffing is present. The PMPM may be reduced if the BHH is not performing the expected activities or maintaining the needed staffing levels.

PMPM – Per Member Per Month; IT – Information Technology; BHH – Behavioral Health Home
Source: Internal data from WellCare Health Plans, Tampa, Florida.
Implications

Consistent with IHI Triple Aim\(^1\)

- Improves member experience
- Improves health of populations
- Reduces per capita health expenditures

Assists in the transition to VBP from FFS

Supports the ACA provision for the creation of BH Homes

IHI – Institute For Healthcare Improvement; VBP – Value Based Purchasing; FFS – Fee For Service; BH – Behavioral Health; ACA – Affordable Care Act


Source: Internal data from WellCare Health Plans, Tampa, Florida.
CLOSING