Community Center Readiness Guide
Additional Resource #12
A Case Study in Health Homes: Missouri Medicaid (MO HealthNet)

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http://www.commonwealthfund.org/Content/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Snapshots/Missouri.aspx

Missouri has pioneered a program for Medicaid beneficiaries with severe mental illness that is based in community mental health centers (CMHCs) and provides care coordination and disease management to address the "whole person," including both mental illness and chronic medical conditions. The initiative is a partnership among Missouri's Departments of Mental Health, MO HealthNet (Missouri's Medicaid agency), and the Missouri Coalition of Community Mental Health Centers. MO HealthNet is preparing a State Plan Amendment to apply for the enhanced federal match under the ACA health home provision to expand the breadth and depth of the program.

"The community mental health center is the logical health home for people with severe mental health conditions," according to Joseph Parks, M.D., chief clinical officer of the Missouri Department of Mental Health. Medicaid beneficiaries with severe mental illness are two to three times more likely to have chronic medical conditions and have a 25-year shorter life expectancy on average than the general population.[1]

CMHCs already see patients as many as several times per month to arrange for mental health and social services, and they foster ongoing, personal relationships with patients, so they have opportunities to coordinate care and help patients adhere to treatment. "It's not a huge expansion to add coordination of general medical treatments, identify gaps, and follow up when those gaps are not being met," said Parks.

"Medicaid's responsibility is to ensure population health," said Ian McCaslin, M.D., M.P.H., director of MO HealthNet. "You can't rationally separate the physical health care side from the behavioral health side." MO HealthNet is planning to also develop a primary care–based health home for people with chronic conditions that do not involve significant mental illness.

Primary Care Nurse Liaisons and Community Mental Health Case Managers

Missouri's CMHC-based health home model leverages an existing mental health system, with added training for providers on chronic conditions as well as the use of data and analytic tools. CMHCs are designated as the central care coordination site for patients without a regular primary care provider. All Missouri CMHCs have a primary care nurse liaison on site to educate the behavioral health staff about physical health issues and train case managers in recognizing and managing chronic medical conditions and coordinating and integrating mental health disease management with Medicaid disease management programs.

In addition to traditional behavioral health case management activities such as assisting with housing, eligibility for benefits, activities of daily living, and adherence to psychiatric medications, the case managers provide services such as assisting with adherence to medications for medical conditions,

scheduling and keeping appointments, and obtaining a primary care provider. They coordinate care across health care providers and between clinic visits.

The CMHCs also integrate physical and behavioral health care by conducting annual screening for hypertension, diabetes, obesity, high cholesterol, and hyperlipidemia as well as specially designed pre-diabetes screening. While the CMHCs traditionally perform psychosocial rehabilitation to improve patients' social skills, under the program the centers have added smoking cessation counseling, obesity and weight reduction instruction for diabetics, and promotion of increased physical activities.

Building Bridges Between Medicaid and Mental Health Departments

A partnership between MO HealthNet and the Department of Mental Health, which funds and oversees the CMHCs, is critical for this model to succeed. Through this initiative, CMHC case managers have access to a Web portal to review the past three years of a patient's Medicaid health care history. Also, the Medicaid administrative claims data provides a wealth of information to help steer efforts; for example, if the nurse liaison sees that certain patients have asthma but their prescription claims do not show inhalers, she alerts the case managers to follow up with those patients.

The relationship has clear advantages to Medicaid. "Behavioral health drives a dramatic portion of Medicaid spending," said McCaslin. "We benefit when the community mental health system links individuals with severe mental illness to case management that ensures access to community supports, transportation, and primary care. We think it's the right approach, and a wise investment."

Building this relationship between state departments may take years, however. "Other states should start working on this relationship immediately," Parks said.

Next Steps

As MO HealthNet prepares its State Plan Amendment, they and the Department of Mental Health have had helpful discussions with CMS. Parks reports that thus far CMS has shown great interest in this model and have been supportive of the underlying principles. The formal proposal to CMS will likely include a three-pronged payment mechanism:

- a flat grant to the CMHC for infrastructure such as lab testing equipment and electronic data interfaces;
- per member/per month payments adequate to cover nurse case management time for health home services; and
- performance rewards to the CMHC, tied to improved outcomes as measured by Healthcare Effectiveness Data and Information Set (HEDIS) measures, reduced hospitalizations, or other indicators.

If CMS approves the State Plan Amendment, Missouri plans to add about 4,000 Medicaid beneficiaries to the CMHC health home program. The Department of Mental Health would provide the non-federal share of the funding. The enhanced federal match will fund more primary care nurse liaisons, specialists at the CMHCs to teach patients how to use personal health records, primary care medical director consultations, and development of electronic data interfaces among the CMHCs, federally qualified health centers, and existing disease registries for better communication and central reporting. Electronic interfaces will

result, for example, in CMHC case managers, primary care providers, and psychiatrists receiving the same prompts (e.g., to refill medications), so that they will all be on the same page and able to give uniform, consistent messages to patients.

"The enhanced federal match will allow us to double the depth, breadth, and effectiveness of what we do," said Parks. In terms of sustaining the program after the two years of greater federal funding ends, Parks is optimistic, in part because a recent study suggested that though the CMHC model can generate higher costs when people first enter care, costs later decline to substantially below what they would otherwise have been. He believes there "will be sufficient savings from disease management and other interventions to break even, but we'll have to prove that."

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Note

[1] T. Lutterman, V. Ganju, L. Schacht et al., "Sixteen-State Study on Mental Health Performance Measures," DHHS Publication No. (SMA)03-3835. (Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003). J. Parks, D. Svendsen, P. Singer et al., Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, 13th in a Series of Technical Reports, October 2006.