Substance Abuse and Mental Health Services Administration

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Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

This webinar/paper/report/product/etc. was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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Partnering for Success: Spotlight on Missouri Medicaid and Department of Mental Health

May 31, 2017

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Faculty

- **Keith Schafer – previously Director Missouri Department of Mental Health (DMH)**
- **George Oestreich – previously Clinical Services Director MO HealthNet (MHD) aka Missouri Medicaid**
- **Joe Parks – previously DMH Medical Director and later Director MHD**
- **Natalie Fornelli – Manager of Integrated Care, DMH, Division of Behavioral Health**

2000-2007: Finding Common Ground

Missouri Medicaid Concerns:	DMH Concerns for DMH Consumers:
High cost of Psychotropic drugs as a % of annual Medicaid Pharmacy costs;	**Inappropriate prescribing/use of psychotropic drugs**;
Disproportionately **high Medicaid costs** for elderly and **disabled populations;**	**High mortality rates, overuse of ER and Inpatient settings and lack of integrated physical/BH care**;
The **need for accurate data** to better manage and report on Medicaid costs for disabled populations; and	**Need for accurate data** to better manage and report outcomes/cost of care; and
The **need for clinical expertise** in policy development and utilization management of Medicaid-eligible populations with serious mental illnesses, substance use disorders and developmental disabilities.	**Need for a stronger relationship** with Medicaid Agency to influence its policies and UM.

The Early Joint Initiatives

- **Joint psychotropic Medication prescriber management Initiatives;**
- **Jointly developed data collection, research and reporting around pharmacy and healthcare utilization for common clients;**
- **Targeting common high-risk clients for special review and management;**
- **Assigning key DMH clinical leaders to work closely with Missouri's Medicaid Division; and**
- **Attending each other's legislative budget hearings and reporting jointly to legislative committees.**

What Our Joint Data Told Us

- **DMH SMI populations, on average, were dying 25 years younger than the general population, but the trend was largely from physical health problems instead of suicide or other forms of violence.**
- **Patients under 40 years old with SMI/SUD tended to over-utilize ERs and community inpatient beds, underutilize outpatient and community support services, and be less compliant with BH medications.**
- **Chronic SMI and SUD patients averaged two additional life-threatening chronic physical health conditions.**
- **A small % of Medicaid high utilizers with SMI/SUD conditions and associated chronic health conditions were contributing to a large % of the state Medicaid program costs.**

What Our Data Told Us

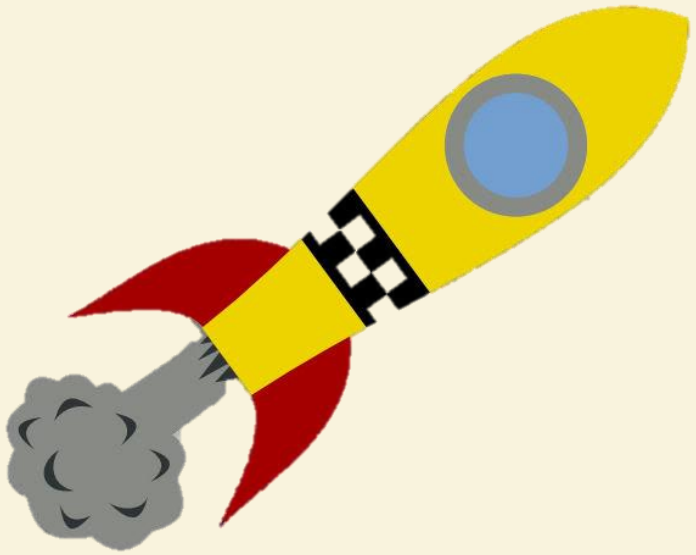
- About 5% of all Missouri prescribers accounted for most of the inappropriate prescribing of psychotropic medications.
- Missouri was prescribing behavioral health medications to children at some of the highest rates in the nation.
- A large % of DMH DD consumers were prescribed behavioral health medications.
- Neither mental health nor medical professionals understood or paid enough attention to the interactive physical and behavioral health problems of DMH and Medicaid patients.

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.**

Rocket Science

Does DMH need Medicaid to succeed?



75% of DMH budget is used for Medicaid match

Missouri Medicaid Reviewed by Lewin Group

- In 2010, Medicaid had a comprehensive review of the program by the Lewin Group
- 58,000 consumers reached $25,000 cost level in CY2008.
- This cohort represented 5.4% of the Medicaid population, but they incurred 52.5% of all Medicaid costs.
- 60% of these had $25,000 each in cost in 2007.

Lewin Findings

- **After adjusting for dual eligibles (Medicare), 23,823 clients reached $25,000 annually in claims cost level. Of those:**
  - ***85%*** *had at least one claim for a mental health diagnosis. Of those:*
  - **30% had a mental health prescription but NO office visit**
- **80% of the high volume med/surg users had evidence of at least one behavioral health condition**

Lessons Learned

- **Inappropriately styled pharmacy edits can cause inappropriate prescribing**
- **Inappropriate prescribing often causes iatrogenic illness and increased PM/PM cost**
  - *Increases in metabolic syndrome*
  - *Increase in ER use*
  - *Destabilization or both SMI therapy and physical therapy resulting in increases in tertiary healthcare cost*
- **Transitional care suffers allowing increased system cost and more rapid progression of chronic disease**

Problem Statement

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

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

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

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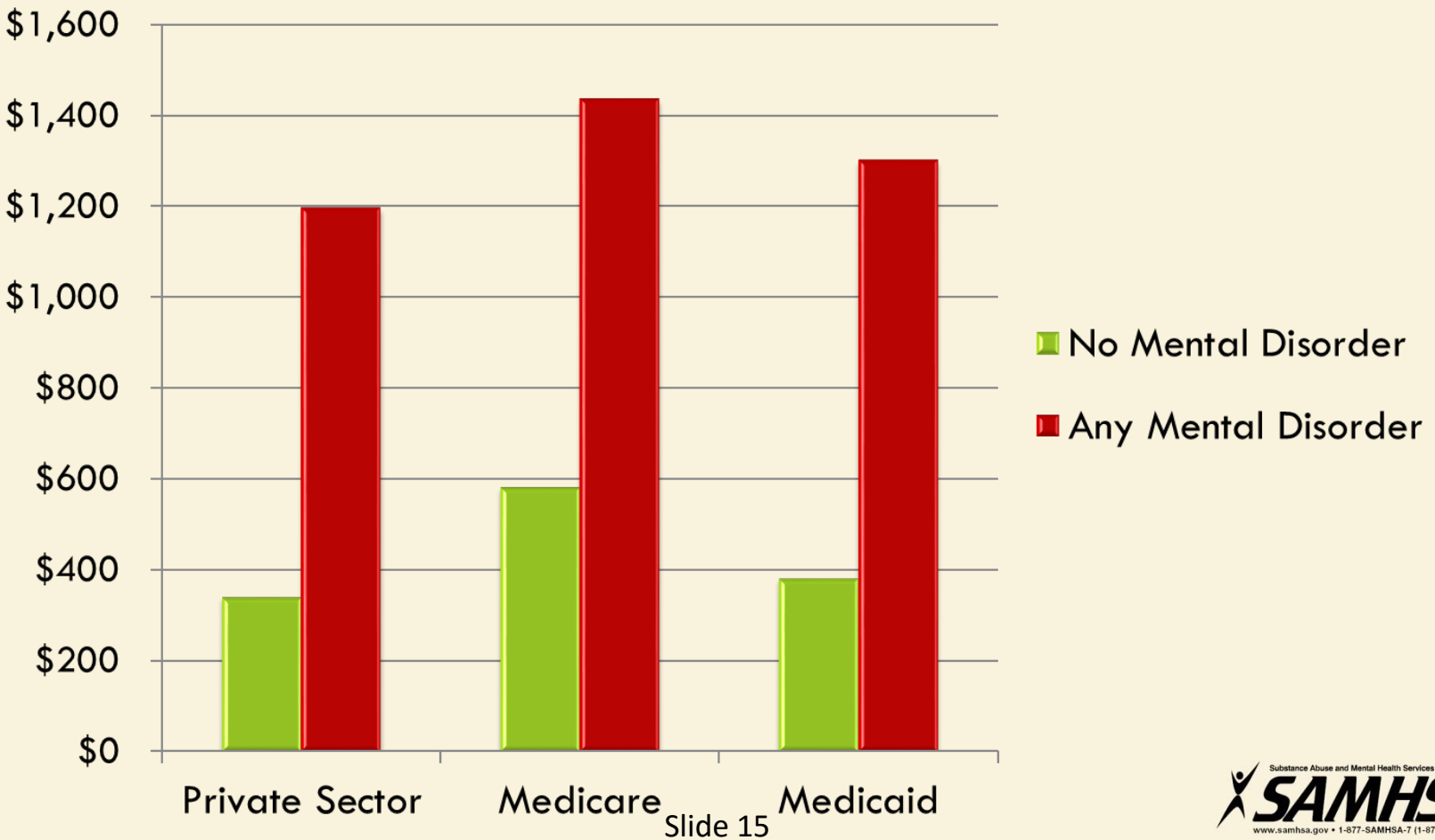
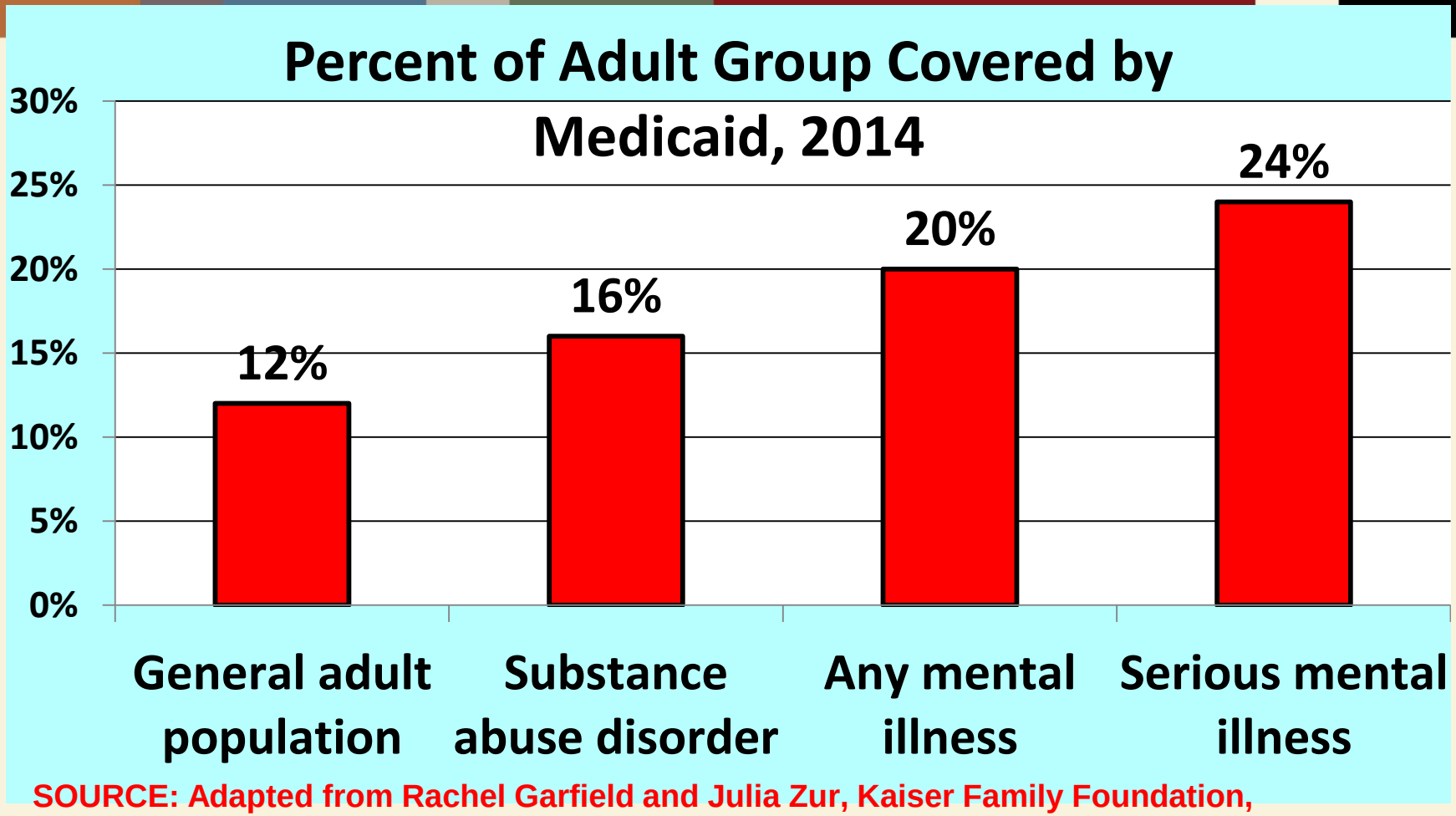
Per Member Per Month Costs





SOURCE: Adapted from Rachel Garfield and Julia Zur, Kaiser Family Foundation, http://kff.org/medicaid/issue-brief/medicaid-restructuring-under-the-american-health-care-act-and-implications-for-behavioral-health-care-in-the-us/

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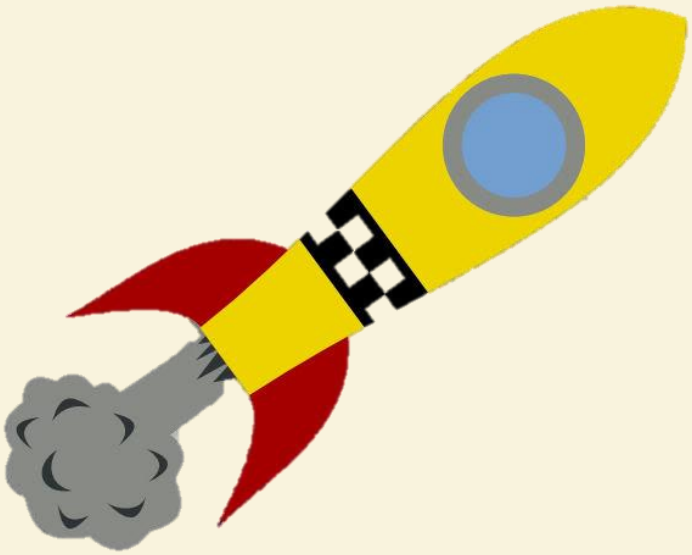
Rocket Science

- **Does Medicaid need DMH to succeed?**



Joint Program Policy and Development

- **Medicaid manuals for DMH programs**
  - *Change in DMH policy drives changes in the Medicaid manuals*
  - *Joint annual review of each manual*
- **New services and program policy**
  - *Collaborative review of DMH developed service proposals, provider definitions, service codes, etc.*
  - *Medicaid Provider Bulletins*

DMH Net

- DMH + MO HealthNet = DMH Net (2003-2011)
- Series of clinical integration projects
- Integrate primary and BH care
- Improve quality of care for persons with SMI

DMH Net

- **Chronic Care Improvement Program (CCIP) 2006-2009**
- **CMHCs began assuring selected clients were receiving Primary Care for chronic conditions**
- **Primary Care case management**
  - *Disease Management*
  - *Care Coordination*

DMH Net

- **Nurse Liaisons (2007-2011)**
- **Nurses added to CMHCs**
  - *Provide primary care follow up in the BH setting*
- **Metabolic Syndrome Screening were introduced to CMHCs and their consumers**
- **Nurse Liaisons became Nurse Care Managers in Health Homes**

Disease Management Programs

- **High cost Medicaid enrollees with SMI and/or SUD, chronic health conditions, and no BH service provider**
  - *DM3700 2010*
  - *ADA DM 2014*
- **High ER and inpatient costs**
- **Outreach and engage in BH services**
- **DSS pays the Medicaid match for the BH services**
- **Significant Medicaid cost savings**
- **October 2012- DM3700 received the Governor's Award for Quality and Productivity: Pinnacle Award**

Behavioral Health and Primary Care Health Homes

- **Joint efforts in:**
  - *Development (SPA, policy, staffing)*
  - *implementation*
  - *training*
  - *publications*
  - *meetings*
  - *memos*
- **Results: Improved clinical outcomes and cost savings**
  - *Medicaid funding for additional enrollment*

Behavioral Health and Primary Care Health Homes

- **Program evaluations**
  - *Urban Institute (annual)*
  - *Rutgers University (ongoing)*
  - *NORC at the University of Chicago (2012)*
- **Data reviews and data sharing**
- **Cost savings**
- **Case studies**
  - *NASCA- Harvard University (2015)*
  - *Pew Charitable Trust (in development)*

Certified Community Behavioral Health Clinics

- Two year demonstration program
- Awarded SAMHSA planning grant in October 2015
- Chosen as one of eight demonstration states in December 2016
- Implementation July 1, 2017

Certified Community Behavioral Health Clinics

- **BIG change = lots of system work!**
  - *Change from FFS to PPS*
  - *Data mapping in various systems*
    - **MMIS (Medicaid)**
    - **CIMOR (DMH)**
  - *Combining how services are billed*
    - **Medicaid Behavioral Health "clinic option'**
    - **DMH community rehabilitation services**

Structural Integration

- None
- Separate cabinet agencies
- Separately Appropriated Budgets
- Separate Regulations
- Separate HR
- Separate resource management

MHD Behavioral Health Operations

- **Benefits – FFS and MCOs**
  - **Inpatient**
  - **Psychotherapy**
  - **Psychiatric Services**
  - **Pharmacy (carved out and managed as FFS to maintain collaboration**
- **Responsibility**
  - **Budget**
  - **Policy**
  - **Operations**

DMH Medicaid Operations

- **Benefits**
  - **Rehab Option for Serious Mental Illness**
  - **Rehab Option for Substance Use Disorder**
  - **4 HCBS Waivers for Intellectual Disability**
  - **CMHC Health Homes**
  - **CCBHCs**
- **Behavioral Pharmacy Management**
- **Opioid Prescription Intervention Program**

It's About Us, Everyday

- **Integration does not depend on:**
  - Organizational structure
  - Consolidated budgets
  - Line authority
- **Integration is a Behavior**
  - How you act with or without each other everyday
  - Integration is about partnership and collaboration

DMH support to MHD Operations

- Up take of Medicaid EHR – CyberAccess
- Assistance on APS Disease Management Initiative
- Support on Integrated Pharmacy DUR and PA committees
- Support on Psychotherapy UR Committee
- Oversight visits to MCOs
- Development of Primary Care Health Homes

Partnership Strategies

- **Systematically discuss the long term relationships as they are more important than the current project**
- **Seek to build mutual dependency and vulnerability. Automatous invulnerable organizations usually behave badly**
- **Hire each others middle managers whenever the opportunity arises**
- **Shamelessly promiscuous exchange of data**

Cross Hiring – MHD to DMH

- **MHD Director of Finance became DMH Director of Medicaid Reimbursements**
- **MHD Director Managed Care Rate Setting became DMH Deputy Director for Developmental Disability Division**
- **MHD Assistant Director became DMH Developmental Disabilities Division Director**
- **MHD Eligibility Specialist became DMH Eligibility Specialist**

Cross Hiring – DMH to MHD

- DMH Director Children's Services became MHD Behavioral Health Director
- DMH Medical Director became MHD Director
- DMH Facility Psychologist became later MHD Behavioral Health Director
- DMH Facility Psychologist became MHD Director for Quality
- DMH Assistant Director became MHD Acting Director then MHD lead on MAGI eligibility IT project
- DMH Developmental Disabilities Division Director is currently acting MHD Assistant Director

Partnership Principles

DON'T

- Talk about your need first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps
- Be afraid of risk

DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team
- Calculated risk produces growth

Partnership Tips

- Only write an MOU if forced to
- Write your MOUs very broad and vague with no end date
- Allow trust to support collaboration
- Share your data!
- Use Motivational Interviewing
- Use Principled Negotiation ("Getting to Yes by Ury and Fisher)

Principled Negotiation

The Method

1. Separate people from the problem
2. Focus on interests, no positions
3. Invent options for mutual gain
4. Insist on using objective criteria

Separate the People from the Problem

Principles

- When dealing with long term associates that the relationship is more important than the particular deal
- Substantive concessions don't solve people problems
- Be tough on the problem and soft on the people

Switch: Patient to Partner and Disease to Project

It is more important to know what manner of patient who has the disease, than to know what manner of disease the patient has.

Sir William Osler

Partnership Mentor- Dancing

- You have to know your partners location, center of gravity, and velocity before doing anything
- It's about opening doors and getting out of the way, not by pushing or pulling in a particular direction
- Successful motion is about where your center goes not what happens with your extremities (demonstration projects are a waste of time)

Partnership Mentor- Dancing

- **Communicating clear and consistent- intentionality is essential**
- **You have to lead at the level that your partner is able to follow**
- **Really skilled partners switch off who leads and who follows**
- **If your partner doesn't look good it's your fault**
- **Always thank your partner no matter how well or poorly things went**

What We Learned

- **Effective leaders are unrealistically optimistic**
- **Rituals are important and powerful**
- **Take the time to get to know your partners incentives and constraints - you will discover resources and opportunities that you never knew existed**
- **Socialize regularly**
- **Organizational culture and professional culture are really important**

Behaviors That Promote Trust

- **Character**
  - *Talk Straight*
  - *Demonstrate Respect*
  - *Create Transparency*
  - *Right Wrongs*
  - *Show Loyalty*

- **Competence**
  - *Deliver Results*
  - *Get Better*
  - *Confront Reality*
  - *Clarify Expectations*
  - *Practice Accountability*

- **Character & Competence**
  - *Listen First*
  - *Keep Commitments*
  - *Extend Trust*

***S.M.R. Covey, The Speed of Trust**

Trust and Collaboration

- Trust promotes collaboration
- Collaboration promotes trust
- Trust and collaboration promotes common problem solving and system successes
- Trust and collaboration decrease parochialism
- Parochialism is the seed of failure