HEALTHY VIRGINIA

Medallion 3.0 Regional Behavioral Health Home Pilot Program

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Overview

Individuals with a serious mental illness (SMI) are typically seen more frequently by a mental health provider than by other medical providers. When presenting with complex medical conditions comorbid with SMI, these individuals often fail to access medical care, face impediments in navigating the health care system, and are less likely to receive adequate care for their medical and behavioral health needs.

Beginning July 1, 2015 as a part of Governor McAuliffe's—*A Healthy Virginia* Plan, the Department of Medical Assistance Services (DMAS) and the Medicaid Managed Care Organizations (MCOs) established regional Behavioral Health Home (BHH) pilot programs to coordinate physical and behavioral health care for individuals insured through the Medallion 3.0 Medicaid managed care program. The BHH initiative aims to improve the delivery of medical and behavioral health care to adult members with SMI and complex medical conditions (e.g. diabetes).

Targeted care services include:

1. Medical and Behavioral health care coordination and care management
2. Evidence-based treatments that are customized to the member's needs
3. Ongoing member support, outreach, and education

Through the Medallion 3.0 program, MCOs are able to utilize flexibilities within the BHH pilot to advance innovation in care management and capitalize on knowledge and experience in working with individuals diagnosed with complex medical issues and SMI.

As of the end of September 2016, there are 205 Medallion 3.0 members participating in the regional BHH pilot program out of a total of 263 eligible members who declined to participate. Startup costs for the BHH pilot programs were offset by administrative funds from DMAS at $100,000 per participating plan for year one of the pilot programs. Some BHH pilots procured clinical case managers and behavioral health managers that captured the majority of the provided administrative funding. Other cost considerations were due to specialized medical home model designs that required outreach strategies to engage both providers and members outside of a centralized location. Programs that expanded in membership or later enhanced pilot service offerings also saw increased pilot costs that were assumed by the respective plan. Administrative funding for the BHH pilot programs was decreased to $50,000 for year two for the cost of pilot maintenance.

PILOT FUNDING VERSUS EXPENDITURES

MCO	Funding	Actual Expenditures
Aetna	$100,000	$100,000
Anthem	$100,000	$100,000
INTotal	$100,000	$160,000
Optima	$100,000	$100,000
Virginia Premier	$100,000	$100,000

Eligibility Criteria

The Medallion 3.0 MCOs developed uniform clinical criteria to define member eligibility for pilot inclusion or exclusion.

Sophisticated predictive modeling is used to identify individuals who are eligible for participation using one or more of these four pathways:

1. Mental health claims history
2. Significant mental health pharmaceutical use
3. History of multiple inpatient admissions and
4. High Emergency Department (ED) utilization rates

Mental health claims history identifies individuals with complex medical needs and SMI diagnoses including schizophrenia, bipolar disorder and delusional disorders. Behavioral health pharmaceutical history for patients who have received six or more specific psychotropic medications prescribed for SMI is a clear indicator of clinical inclusion criteria. History of inpatient psychiatric hospitalization coupled with a SMI diagnosis is also used to identify eligible individuals. Lastly, history of ED utilization, with four or more visits, coupled with a SMI diagnosis identifies eligible members.

Pilot Model Descriptions

Two models of care integration for non-traditional behavioral health and transportation services were defined and implemented.

DEFINED PILOT OPTIONS

***Option A Pilots* – 4 MCOs**	***Option B Pilots* – 1 MCO**
Entered into a business-to-business agreement with DMAS' Behavioral Health Service Administrator – Magellan – to provide access to traditional and non-traditional behavioral health and transportation services	MCO manages all services

All BHH pilot programs have a dedicated team of case managers and care coordinators assigned to each participating member. BHH care coordination is driven by the clinical teams who consult one another as they are all equally dedicated to improving the lives of people suffering with SMI.

The pilot programs are built off of these two core models but are unique in organization of their medical home models and their enhanced service offerings. Each pilot offers their BHH pilot in different regions of the state with a variety of community partners, such as, Community Service Boards (CSB). For detailed information on each pilot program please visit http://tinyurl.com/BHH-MCO-Pilots.

MCO PILOT PLAN DESCRIPTIONS

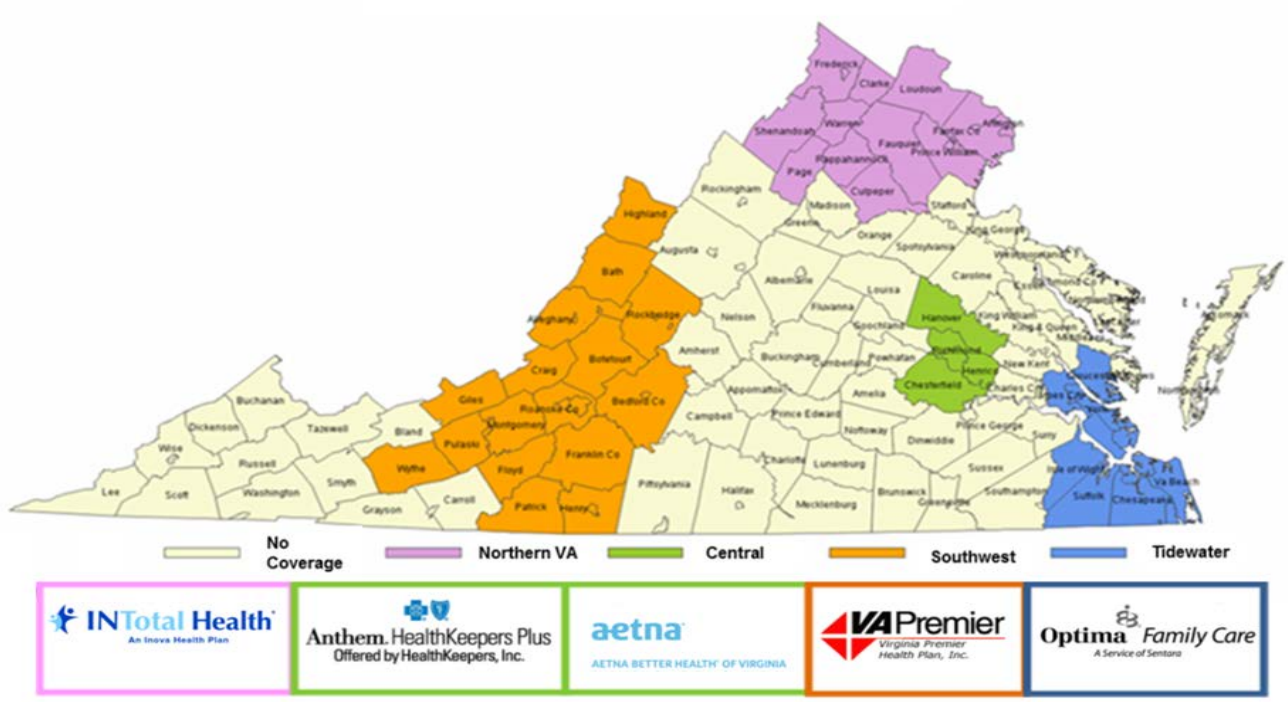
MCO	BHH Unique Pilot Attributes	Projected Number of Pilot Participants	Number of Members Served
Aetna	A hybrid design consisting of an in-house/co-located partnership and facilitated referral model with the goal to keep the majority of member care to the least number of sites as possible and to have more efficient and effective provider collaboration, Dedicated care manager	75	19

Anthem	Established BHH pilot based on the Enhanced Care Coordination model. The pilot includes a dedicated community-based care manager and a co-located registered nurse within the CSB pilot partner. The only plan to provide all medical, traditional & non-traditional BH treatments, services, and related transportation	30	27
INTotal	Pilot program care integration at the health plan and coordination of care level and at the point of service level, Member specific treatment approach with dedicated Care Manager, Provider to member home visits, Focus on cultural competence and awareness	150	58
Optima	A blended/ co-located and facilitated referral model approach, Dedicated care manager, Use of Health Information Technology (HIT) to support coordination of care with partners of the provider community and gathers quality improvement data, Individualized care and treatment plans	50	34
Virginia Premier	Pilot built upon existing Behavioral Health (BH) community partnerships for tailored treatment approaches and maximizing health outcomes, Single site service for BH and primary care and care coordination only services	100	67

Pilot Regions and Localities

Each BHH pilot program serves members in a select area of one of the seven Medallion 3.0 Medicaid managed care regions of the state. The central region has two pilot programs administered by Aetna and Anthem. The Northern Virginia region has one pilot program offered through INTotal. The Tidewater region has two BHH pilot programs offered through Optima Family Care and Virginia Premier. Regional localities were identified by the respective MCOs and based on significant number of eligible members for the selected locality *(Figure 1)*.

Figure 1. Behavioral Health Home Pilot Program Regions and Localities



BHH Pilot Program Goals

1. Improve mental and physical health outcomes for pilot participants
1. Empower medical and behavioral health providers to work together to provide the right care to the right person at the right time and place and
2. Provide opportunity to evaluate pilot programs and processes

Pilot Achievements

As the pilot year proceeded, the mechanism for reporting pilot progress evolved and was standardized in April 2016. Key pilot program measures included - Follow-Up Post 30 Days of Behavioral Health Inpatient Discharge. All BHH pilot programs reported following up with 100% of members who were discharged after an inpatient hospital stay due to behavioral health reasons. This score is self-reported and the official National Committee for Quality Assurance (NCAQ) Quality Compass Healthcare Effectiveness Data and Information Set (HEDIS) scores will be released in October 2016. HEDIS is the national gold standard used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The reported scores for this measure will be matched to the official NCQA scores upon their release. The two other pilot performance measures were (1) BHH care team monthly member contact and (2) MCO care manager to member contact. Below are BHH pilot achievement highlights:

1. Pilot participation ranged from a high of 230 members to a low of 205 members
2. BHH Care Team monthly contact percentages ranged from 34% to 54%
3. MCO care manager monthly contact ranged from 40% to 54%
4. The number of medical and psychiatric hospitalizations for participating pilot members ranged from 2 to 18
5. Follow-up after hospitalization for physical and/or behavioral health illness:
    - Follow Up After Hospitalization for Mental Illness within 30 Days = 100%

Fluctuation in member participation was mainly due to members agreeing to participate and then deciding to not participate after they began the pilot. Changes in Medicaid eligibility also impacted member participation in some cases. Plans indicated that in a few cases, despite diligent efforts, monthly member contact proved to be difficult for a variety of reasons including non-responsiveness to attempted contact, potential changes to provided contact information without the plan being informed, and being unable to gain and/or maintain a level of trust where the member felt comfortable participating or continuing to participate in the pilot program. The post hospitalization follow-up scores and decrease in member hospitalizations for the BHH pilot program are likely due to the pilot's medical home and team-based approach to member care. The multifaceted coordination efforts of pilot MCOs, providers, and community partners allowed for streamlined access to medical and behavioral health care for pilot members.

Additionally, the regional BHH pilot programs have shown success in delivering on the Governor's - *A Healthy Virginia* Plan - targeted goal of providing improved access to behavioral and medical health care for individuals with SMI and complex illnesses in specialized coordinated care settings through the use of the medical home model of care. Although the total number of participating members is small relative to the total Medicaid managed care adult population, the year one pilot achievements in member care indicate that BHH pilot members are receiving improved access to both physical and behavioral health care with an unsurpassed level of timely follow-up care from the pilot medical home teams. In keeping with the positive trends that the members are experiencing through the BHH pilot programs, the commonwealth's most vulnerable Medicaid members are receiving high-quality, effective physical and behavioral health care outside of out of hospital emergency rooms and inpatient settings.

BHH Pilot Member Care Highlights

HIGHLIGHT ONE

A pilot member presented with high blood pressure and SMI reported being unable to regularly self-monitor blood pressure. Through the BHH pilot care team and care coordination approach to care, the client received a blood pressure monitor, blood pressure charting materials and disease management education. The MCO's BHH pilot care team and care manager worked with the individual's group home to educate the staff about improving administration of medications for individuals with similar illnesses. From that point forward, the individual's blood pressure readings were consistently monitored and within normal limits, indicating controlled hypertension.

HIGHLIGHT TWO

An individual participating in the BHH pilot program was diagnosed with Paranoid Schizophrenia, HIV, and numerous other chronic and pervasive complex medical issues. The individual lacked insight regarding the medical issues and medically necessary treatements that were needed. The individual was involuntarily admitted to a psychatric hopital for behaviors due to non-medicaiton adhearence. Due to the BHH pilot's behavioral health home model of care, the BHH Care Team and the dedicated MCO care manager were able to work closely with the CSB case manager and hospital to expedite guardianship to allow for

necessary medical treatement. The individual recevied the necessary medical treatments and continues to work towards mental health stabilization in the psychiatric hospital.

Summary and Next Steps

The BHH pilot programs experienced some challenges regarding member acceptance treatment refusal and keeping participants in the program after electing to participate. The pilot's medical and behavioral health providers noted having experienced these areas of difficulties for this complex population prior to the pilot program for both Medicaid members and non-Medicaid members. Other program challenges included provider specific data sharing, connecting with members for outreach and education efforts, low participation rates and loss of participant Medicaid eligibility.

Despite these challenges, the pilot program's scores on the National Committee for Quality Assurance (NCQA) measure for post hospitalization follow-up attests to pilot achievement in the areas of access to care and continuity of care. Plans reported a significant decrease in hospitalizations and ED visits for participating individuals during this first pilot year which benefits the commonwealth on two fronts: effective member care and care cost. Due to these successes, the BHH pilot program has been extended to the 2016-2017 Medallion 3.0 Medicaid managed care contract year. For year two of the BHH pilot program DMAS is scheduling site visits to each of the participating Medallion 3.0 MCOs to continue to refine and evolve their pilot programs as we learn more about the special needs of this population. Pilot program reporting will continue and expand to include a broader range of health outcomes for participants and success markers as the program matures.

Follow-up Inquiries

For inquiries regarding the Medallion 3.0 Regional BHH Pilot Program please contact the program's administrator via email: BHHPilot@DMAS.Virginia.Gov