



# Integrated Care Delivery in Medical Assistance

Brett Davis

Wisconsin Medicaid Director

Linda Harris

Division Administrator

Division of Mental Health & Substance Abuse Services



# Topics for Discussion

- Wisconsin Medicaid
- Integrated Care Model
- Key Findings
- Feedback and Next Steps



# The Wisconsin Medicaid Challenge

- How do we create a fiscally sustainable medical assistance program and improve value for members at the same time?
- The VALUE proposition = 
$$\frac{\text{Quality}}{\text{Cost}}$$
- Costs have risen consistently, while the share of Federal funding available for the Medicaid program has declined
- Even after an infusion of \$1.2 billion of additional state funding for the current budget cycle, we needed to find savings to keep the program in balance with the state budget
- Based on December 2012 estimates, the Medicaid program is projected to be in balance for the biennium
- The cost to continue the medical assistance program for the 2013-2015 biennium is approximately \$650 million in additional state tax dollars, primarily due to a significant loss in federal revenues and the removal of the Family Care cap



# Wisconsin Medicaid: Overview

Enrollment by Program Type			
	March 2011	March 2012	March 2013
<b>BadgerCare +</b>	776,569	777,267	758,242
Children	415,054	422,506	430,801
Parents/Caretakers	224,065	226,242	226,060
Pregnant Women	18,441	18,447	18,125
Childless Adults	40,137	26,808	19,172
<b>Elderly, Blind and Disabled</b>	193,417	200,244	202,938
SSI	100,581	101,834	101,709
<b>Other Medicaid Programs</b>	194,320	199,870	204,640
<b>Total Managed Care Enrollment</b>	736,693	746,391	685,803
BadgerCare + HMO	667,787	673,219	610,627
SSI HMO	31,259	33,441	33,657
<b>Total Medicaid Enrollment (FFS and Managed Care)*</b>	1,164,306	1,177,381	1,165,820
<b>MA Budget (\$ in Billions)</b>	6.55	6.8	7.2



\* approximately 983,000 are “full-benefit” MA recipients

# Why Integrated Care?

- In Wisconsin, three-quarters of the population receiving full-benefit Medicaid services is in some form of managed care
- Many of those that remain in the fee-for-service system have multiple, complex needs that cross-cut several different systems
- One example being individuals with a behavioral health diagnosis who are currently in our SSI fee-for-service population
- This population could benefit from more coordinated, targeted care delivery that incorporates providers across the care continuum
- Benefits to individuals with diverse medical needs may include better access to care, care coordinators to assist with navigating the system to address different physical and behavioral health issues, and overall improvements in health





# Why Integrated Care?

## Basic Figures:

- On average, individuals with serious mental illness have an average life expectancy 25 years lower than the general population, primarily due to physical health issues
- People with co-occurring disorders have a life expectancy 30 years lower than the general population
- The likelihood of depression increases with each additional comorbid chronic medical condition
- People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared with people without these mental disorders

## National Medicaid Trends:

- Approximately 5% of Medicaid beneficiaries nation-wide with mental illness account for 50% of Medicaid spending
- Half of Medicaid beneficiaries with disabilities have behavioral health comorbidity
- The addition of mental illness and substance use disorder to chronic medical conditions is associated with a 3 to 4 times increase in cost



# What is Integrated Care?

DHS defines integrated care as:

- Comprehensive team-based health care, meeting physical, mental health, and substance care needs
  - Team for each individual includes primary care provider, medical case manager, mental health or substance abuse professional, and care coordinator
  - Other members of team may include variety of professionals based on unique needs/preferences of individual
  - Lead for care coordination will be based on assessed need and patient's choice
- Care includes prevention and wellness as well as acute and chronic care management
- Care provided is person-centered, recovery-oriented, trauma informed, evidence-based and culturally competent



# What is Integrated Care?

## Clinical Features of Integrated Care:

### ■ For Individual:

- Comprehensive assessment upon enrollment
- Annual preventive care screenings
- Active individual engagement in care
- Transitional care
- Referrals to community and social support services

### ■ For Population:

- Clear care coordination policies and processes, with flexibility for individual needs
- Comprehensive services /providers with specialized expertise in areas to address needs of population
- Quality improvement, including use and monitoring of quality measures
- Providers accountable for patient care and outcomes



# Goals of Integrated Care Delivery in Wisconsin

- Pilot integrated care program in North Central Wisconsin
  - Improved Health Care Value for Medical Assistance Members
    - Better Health Care Quality
      - Defined performance metrics for measures of behavioral health, chronic disease management, and consumer satisfaction
    - Reduced Costs
      - Comparing total spend on members enrolled in integrated care model to fee-for-service members over an extended time period (e.g. 3 years)
  - Expansion to additional geographic areas if goals are achieved





# Integrated Care Delivery in Wisconsin Medical Assistance: Data

- Source of Data: Medicaid claims -three year period- CY 2009-2011
- Medicaid Population Included in the Data:
  - Adults-aged 18-64 enrolled in Medicaid fee-for-service throughout Wisconsin (no Medicare)
  - One or more diagnoses of Mental Illness or Substance Abuse – defined by Agency for Health Care Research and Quality (AHRQ) Clinical Classification Software (CCS)





# Key Findings from the Data

## State-wide Demographics (2009-2011):

- Average age: 41 years old
- 51% Female, 49% male
- 10% received/receiving county care management services (CSP, CCS, and/or TCM)

## Statewide Cost:

2009: 17,457 recipients with average cost of \$19,140

2010: 16,966 recipients with average cost of \$19,214

2011: 17,477 recipients with average cost of \$19,907

\*Average annual cost of: BadgerCare Plus Adult is approximately \$3,200

SSI Adult is approximately \$7,800



# Key Findings From the Data

- **Population Categorized by Behavioral Health Condition\*:**
  - **Severe (e.g. serious and persistent mental illness)**
    - 87% of population
    - Average per-person cost in 2011: \$20,875
  - **Moderate (e.g. temporary mental illnesses such as situational depression or adjustment disorders)**
    - 13% of population
    - Average per-person cost in 2011: \$11,883

*Costs do not include county share or WIMCR adjustments*

\*Behavioral health categories defined by Division of Mental Health and Substance Abuse Services





# Key Findings from the Data

## Top 10 Behavioral Health Diagnoses (2011)\*:

Diagnosis	Percent of Recipients
TOBACCO USE DISORDER	44%
DEPRESSIVE DISORDER	35%
ANXIETY STATE	25%
BIPOLAR DISORDER	15%
DYSTHYMIC DISORDER (depression with regular low moods)	11%
EPISODIC MOOD DISORDER	10%
ALCOHOL ABUSE	9%
POSTTRAUMATIC STRESS DIS	9%
ATTN DEFICIT WITH HYPERACTIVITY	9%
SCHIZOPHRENIA	9%

\*Diagnoses are not mutually exclusive and are reflective of the full population



# Key Findings from the Data

## Top 10 Prescription Medications (2011):

Name of Prescription	Number of Prescriptions
HYDROCODONE-ACETAMINOPHEN (pain)	29,989
OMEPRAZOLE (gastric ulceration and gastritis)	24,531
CLONAZEPAM (anti-seizure/epilepsy)	16,085
SEROQUEL (schizophrenia or bipolar disorder)	15,034
GABAPENTIN (primarily anti-seizure but also pain)	14,664
OXYCODONE HCL (pain)	12,909
LORAZEPAM (anxiety)	12,447
TRAZODONE HCL (anti-depressant)	12,367
CITALOPRAM HBR (anti-depressant)	12,195
RISPERIDONE (antipsychotic)	11,464



# Key Findings from the Data

## Top 10 2011 ER Primary Outpatient Diagnoses

2011 PRIMARY ER DIAGNOSIS	Percent of Visits
HEADACHE	15%
CHEST PAIN	15%
ABDOMINAL PAIN	12%
LUMBAGO (lower back pain)	11%
ABDOMINAL PAIN OTHER/MULTI SITE	11%
MIGRANE	11%
OTHER CHEST PAIN	10%
URINARY TRACT INFECTION	8%
DENTAL DISORDER	8%
SICKLE CELL ANEMIA WITH CRISIS	7%



# Key Findings from the Data

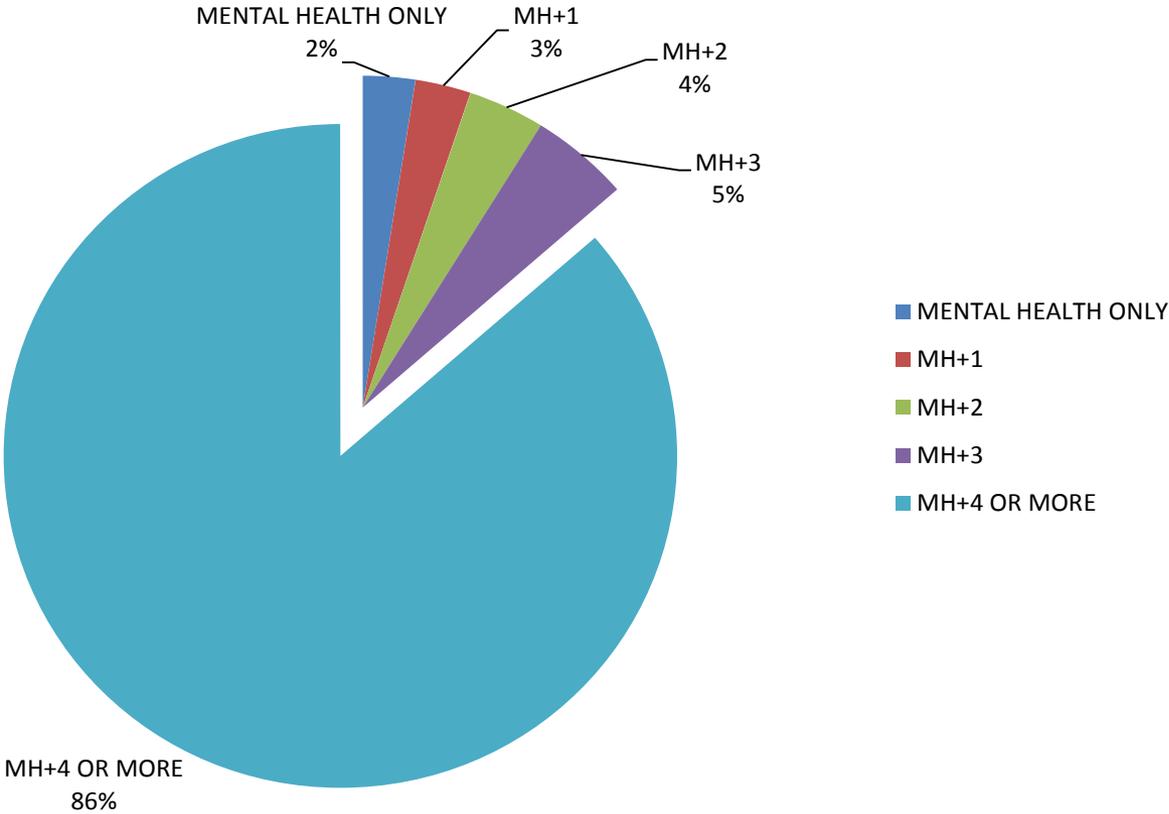
## Top 10 2011 Inpatient Diagnosis Related Groups (DRGs)

DIAGNOSIS RELATED GROUP DESCRIPTION	PERCENT OF STAYS
PSYCHOSES	21%
GASTROINTESTINAL DISORDERS	6%
ALCOHOL/DRUG ABUSE OR DEPENDENCE WITHOUT REHAB	6%
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	5%
SEPTICEMIA ( INFECTION IN THE BLOOD) WITH MAJOR COMPLICATING CONDITIONS	5%
VAGINAL DELIVERY WITHOUT COMPLICATIONS	4%
RED BLOOD CELL DISORDERS	4%
CHEST PAIN	4%
SEIZURES	4%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH COMPLICATING CONDITIONS	4%



# Key Findings from the Data

## Chronic Conditions Among the Population\*:



\*Chronic Conditions defined by Agency for Health Care Research and Quality Clinical Classification System



# Key Findings from the Data

## Recipients with Physical Chronic Conditions

CHRONIC DIAGNOSIS	Percent of Recipients
HYPERTENSION	65%
DIABETES UNCOMPLICATED TYPE II	44%
HYPERLIPIDEMIA (high cholesterol)	39%
ESOPHAGEAL REFLUX	32%
ASTHMA	31%
OTHER CHRONIC PAIN	25%
OBESITY	20%
CHRONIC AIRWAY OBSTRUCTION	19%
BENIGN HYPERTENSION	18%
HYPOTHYROIDISM (low thyroid)	17%
LUMB/SAC DISC DEGENERATION (lower back)	13%
EPILEPSY	13%
PURE HYPERCHOLESTEROLEMIA	13%
DIABETES UNCOMPLICATED TYPE II UNCONTROLLED	12%
MIGRAINE	11%





# Member Profiles

**Member A is a 28 year old female**

- **County -Community Support Program (CSP)**
- Schizophrenia (Severe )
- Total Cost 2011: \$347,826
- 33 separate medications- most prevalent medication is Benztropine Mesylate (Parkinson's Disease)
- Numerous Mental Health/Substance Abuse Services including Crisis Intervention, Occupational Therapy, and Mental Health Treatment and Diagnoses, 123 Home Care Visits, 71 Physician Office Visits and 24 Emergency Room Visits
- Other Symptoms/Diagnoses: Paranoid Schizophrenia, Myopia (near-sightedness)



# Member Profiles

**Member B is a 49 year-old male**

## No County Services

- Schizophrenia (Severe)
- Total Cost CY 2011: \$2,030,898
- 10 Separate Medications- most common: Provigil (excessive sleepiness-narcolepsy) and Nicotine Patch
- 15 Emergency Room Visits, 16 Hospital stays which included 220 separate procedures and tests, 48 Physician Office Visits
- Symptoms/Diagnosis Include: Chest Pain, Anxiety, Bipolar Disorder, Dislocated Vertebrae, Skin Infections, Multiple Sclerosis, Pulmonary Embolism(blockage of main artery in the lung) and Pleural Effusion ( fluid build-up in the lungs)



# Creating an Environment for Integrated Care

There has been a national movement towards more coordinated and/or integrated care:

- Patient-Centered Medical Homes
- Regional/State demonstration pilots and models integrating primary care and behavioral health services
  - *Rethinking Care* Program (PA, NY, CO, WA)
  - Local level initiatives in Michigan
  - Community Care of North Carolina
  - Medi-Cal Managed Care program
- Primary Care Case Management
- Accountable Care Organizations
- Medicaid Health Homes
- SAMHSA Medical Homes
- State Medicaid Director Letter outlining different state options for Integrated Care Models (ICMs)





# What are the Drivers of Success?

Key areas that contribute to success of integrated care models (learning from other states as well as Wisconsin's experience with Medicaid population with diverse medical needs):

- Member engagement
- Clearly identified population(s)
- Aligned financial incentives (state, counties, health plans, providers)
- Multidisciplinary care teams accountable for coordinating full range of services (including a clinical case manager and pharmacist)
- Clearly defined roles and responsibilities among care team members
- Qualified provider networks
- Clinical information system/information exchange
- Clearly defined goals and measurement of outcomes to determine if goals are being met
- Mechanisms for assessing and rewarding high quality care
- Co-location of behavioral health and primary care services
- Aligning benefits to individual's needs





# Health Home Quality Metrics

CMS recommends core set of quality measures for assessing health homes in all states:

- Adult Body Mass Index Assessment
- Ambulatory care-sensitive condition admission
- Care Transition-record(s) transmitted to health care professional
- Follow-up after hospitalization for mental illness
- Plan-all cause readmission for inpatient stay
- Screening for clinical depression and follow-up plan
- Initiation and engagement of alcohol and other drug dependence treatment
- Controlling high blood pressure





# Current DHS Quality Metrics

In addition to measures recommended by CMS, the Wisconsin Medicaid program has utilized a number of measures for other programs including P4P programs with HMOs and hospitals. Examples include:

## Behavioral Health Measures

- Follow-up after hospitalization for mental illness within 7 days
- Follow-up after hospitalization for mental illness within 30 days
- Antidepressant medication management – Acute
- Antidepressant medication management – Continuation
- Initiation in AODA treatment
- Engagement in AODA treatment



# Current DHS Quality Metrics

- Chronic Disease Measures
  - Comprehensive diabetes care – HbA1c
  - Comprehensive diabetes care – LDL
  - Tobacco cessation (18 & older, counseling and pharmacotherapy)
  - Asthma Management, appropriate medications for people with asthma
- Hospital Readmissions
  - 30-Day hospital readmission





# Next Steps

- Tentative Timeline of Behavioral Health Integrated Care in Wisconsin:
  - Spring 2013: Submit Federal Medicaid State Plan Amendment
  - Summer 2013: Finalize qualifications for behavioral health home as well as performance measures
  - Fall 2013: Finalize rate methodology
  - Fall 2013: Sign contract with health home
  - Late fall 2013/early 2014: Enrollment begins





# Next Steps

- Stakeholder Input
  - How do we solve Wisconsin's Medicaid challenge?
  - What performance metrics are critical to the success of this project?
  - How can we collaborate to develop a comprehensive, coordinated service delivery model that will meet the stated goals?
  - Any additional feedback, questions, comments?

\*Please email Sean Gartley, [sean.gartley@wisconsin.gov](mailto:sean.gartley@wisconsin.gov), by May 10<sup>th</sup> with any feedback and/or questions you have after today's meeting.



# Appendices: References

- Kronick et al., “The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions.”
- Center for Health Care Strategies, October 2009; C. Boyd, et al. “Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivery of Clinical Services.” Center for Health Care Strategies, December 2010.
- Carney CP, Jones L, Woolson RF. “Medical comorbidity in women and men with schizophrenia: A population-based controlled study.” *Journal of General Internal Medicine*, vol. 21, no. 11, 2006.
- Carney CP, Jones LE. “Medical comorbidity in women and men with bipolar disorders: A population-based controlled study.” *Psychosomatic Medicine*, vol. 68, no. 5, 2006.
- Melek S, Norris D. *Chronic Conditions and Comorbid Psychological Disorders*. Seattle: Milliman, 2008.



# Appendices: References

- Katon WJ, 2003; Egede LE. “Major Depression in Individuals with Chronic Medical Disorders: Prevalence, Correlates and Association with Health Resource Utilization, Lost Productivity and Functional Disability.” *General Hospital Psychiatry*, vol. 29, no. 5, 2007.
- Stein MB, Cox BJ, Afifi TO, Belik SL, Sareen J. “Does co-morbid depressive illness magnify the impact of chronic physical illness? A population-based perspective.” vol. 36, no. 5, 2006.
- Eaton WW, Martins SS, Nestadt G, Bienvenu OJ, Clarke D, Alexandre P. “The burden of mental disorders.” *Epidemiological Review*, vol. 30, no. 1, 2008.
- Felker B, Yazell JJ, Short D. “Mortality and medical comorbidity among psychiatric patients: A review.” *Psychiatric Services*, vol. 47, no. 12, 1996.
- Colton CW, Manderscheid RW. “Congruencies in increased mortality rates, years of potential life lost, and causes of death among public behavioral health clients in eight states.” *Preventing Chronic Disease*, vol. 3, no. 2, 2006.



# Appendices: CCS Categories

CCS Diagnosis Category Labels: Mental Illness	Diagnosis Categories
Adjustment disorders	650
Anxiety disorders	651
Attention-deficit	652
Delirium	653
Developmental disorders	654
Disorders usually diagnosed in infancy	655
Impulse control disorders	656
Mood disorders	657
Personality disorders	658
Schizophrenia and other psychotic disorders	659
Alcohol-related disorders	660
Substance-related disorders	661
Screening and history of behavioral health and substance abuse codes	663
Miscellaneous disorders	670

