



Mental Health and Co-Occurring Conditions



*An Innovative
Perspective*

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Need for Focus on Co-morbidity

- The 2003 National Comorbidity Survey Replication (NCS-R) reported that more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder had a comorbid mental health condition
- The National Association of State Mental Health Program Directors (NASMHPD) in its 2006 Morbidity and Mortality in People with Serious Mental People with Serious Mental Illness found that in some states individuals with serious mental illness were dying 25 years earlier than the general population and frequently the cause of death were treatable health concerns such as Metabolic Disorders, Cardiovascular Disease, Diabetes Mellitus Disease, and High Prevalence of Modifiable High Prevalence of Modifiable Risk Factors (Obesity, Smoking)

Challenges

- Ensuring that co-morbidities are addressed at client level
- Behavioral health staff have access to data on the medical needs of individuals served (and are eligible to be served)
- Financing models that support needed clinical activities

Ensuring Co-morbidities are Addressed at the Client Level

- The delivery system needs to support these activities by ensuring that there are:
 - Comprehensive assessments that capture behavioral health and somatic information
 - Immediate access to medical staff and understanding of each other's language
 - Behavioral health treatment goals that include specific medical concerns
 - Ease of communication between providers by addressing data sharing barriers
 - Payment for care coordination and all necessary activities
 - Strong accountability and oversight

State Structures

- Carve-in: Medicaid Managed Care Organizations (MCOs) who are paid a capitated rate for both behavioral health and somatic care
- Carve-out: MCOs are responsible for only somatic care. Specialty behavioral services are under the auspices of the state behavioral health and or Medicaid systems
- Services are basically unmanaged and operate under a Medicaid fee for service structure

Important to note payment methodologies for behavioral health may not vary in the different models. Most commonly a fee for service structure is used for behavioral health.

Models

- All populations need both behavioral health and somatic needs addressed but different populations require different models
- Building on the Chronic Health Home initiative for individuals with serious behavioral health needs under Section 2703 of the Affordable Care Act a number of states have selected individuals with serious mental illness and/or Substance Use Disorders as the primary chronic condition to address
 - Maryland's experience with a Chronic Health Home program that targeted those with behavioral health disorders is the following:
 - Funding for care coordination and hiring of medical nurses within behavioral health settings
 - Access to both behavioral health and somatic care data
 - Ability to identify high ED and inpatient users
 - Behavioral health providers are able to focus on specific diseases such as asthma, diabetes and high blood pressure

Specialized Initiative for Individuals with Serious Mental Illness

- Bundled case rate program in Baltimore for individuals with serious mental illness who had long stay hospital stays and/or repeated psychiatric inpatient and emergency service
- There is a single rate that pays for all needed services.
- Behavioral health Medicaid costs are part of the rate.
- Well defined outcomes (housing, employment, quality of life, linkage to medical care)
- Incentives and risks that are assumed by the provider
- Model for expanding the financing structure, clinical expectations and outcomes areas to include greater focus on somatic care

Future Opportunities

- Getting the attention of different payers such as Medicare and commercial insurers
- Opportunities to provide better and more integrated care
- Platform to test out different payment methodologies including value based financing, measurement care as well as collaborative care in primary care settings