Creating Behavioral Health Homes

Strengthening Virginia's Behavioral Health System through Innovation

Importance to Virginians

Half of all individuals who are intensive users of the health care system have a behavioral health diagnosis. This means that in addition to their physical health needs, these individuals also require a level of care to meet their mental health needs. Many medical providers, however, often lack specialized experience to treat mental health conditions. As a result, adults and children who live with serious mental health conditions have difficulty obtaining timely, high-quality care.

Many seek help in emergency departments, often resulting in fragmented care that triages one problem at a time. Social factors such as poverty, transportation limitations, and homelessness place additional strain on overall health. Further complicating the picture is the fact that nearly 50 percent of individuals with an SMI also have a substance use disorder. It's not surprising, then, that Medicaid costs for individuals with both a chronic physical health disease and mental health diagnosis are 75 percent higher than those for people without a mental health diagnosis.

Goal

DMAS, in collaboration with the Department of Behavioral Health and Developmental Services, will establish health homes to coordinate care for adults and children who are insured through Medicaid and who have a serious mental illness or a serious emotional disturbance. These health homes will adopt a "whole person" philosophy for treatment that calls for team-based care of all primary, acute, behavioral health, substance abuse, and long-term services. Virginia will use health homes to enhance the treatment of both mental and physical health conditions and significantly decrease the level of impairment experienced by these individuals. This program could help up to 13,000 individuals in Virginia with serious mental illness.

Issue Background

The earliest effort to coordinate care for Virginians with SMI began in 2009. A New Lease on Life, a project of the Virginia Health Care Foundation, awarded $2 million to nine partnerships, each one comprised of a community services board (CSB) and either a Free Clinic or a community health center. The funding, distributed over three years, was used to support new providers and clinical staff. Those partnerships are now self-sustaining.

A second program, Enhanced Care Coordination (ECC), is a collaboration involving DMAS, CSBs, CMS and three managed care organizations as part of the Commonwealth Coordinated Care Program. The program is designed for individuals with an SMI and one or more chronic medical conditions who are eligible for both Medicare and Medicaid. ECC staff provides support to these

individuals by arranging transportation, accompanying them to primary care appointments, and assisting them to adhere to recommended treatments.

While these efforts and others in local communities are ongoing, they do not serve the entire eligible population of adults with SMI or children with serious emotional disturbances. The Affordable Care Act created an optional Medicaid benefit for states to establish health homes to improve care for adults and children with significant behavioral health needs. Health homes are not physical spaces, but refer to a model of care in which all an individual's primary, acute, behavioral health and long-term services are coordinated and integrated. Participating states can receive a federal financial match of approximately 90 percent for Medicaid administrative expenditures over 24 months (note this enhanced financial match, however, does not apply to covered treatment services).

Strategies for Success

DMAS is creating the Behavioral Health Home Pilot project to deliver integrated health home support for individuals who are in managed care or who are in the fee-for service delivery system. DMAS plans to partner with one or more health plans, CSBs, Federally Qualified Health Centers (FQHCs), Magellan of Virginia, and other key stakeholders to implement the project. The pilot project is designed to meet individuals where they are. This may include bringing primary care services on site at behavioral health clinics. Individuals eligible for the pilot would be automatically enrolled, with the opportunity for them to opt out if they did not want to participate.

Features of this pilot project will include:

- A focus on prevention and early intervention.
- Facilitation of joint treatment planning sessions among providers.
- Strategies to close gaps in care and address societal factors that discourage individuals from seeking medical services.
- Robust use of care management, outreach and community services.
- Carefully managed transitions in care and medications.
- Peer support specialists for assistance with social and lifestyle changes.
- Coordination of care through use of technology to share critical health information.
- Use of data to better understand health care needs.

Timeline

Virginia will phase in implementation of health homes, beginning July 1, 2015, in Southwest Virginia. In the Southwest, primary and specialty health care is limited and difficult to access, and the need for more intensive substance abuse treatment is urgent due to the high incidence of addiction to prescription pain medications.

Measures of Achievement

States that offer health homes are required to report to CMS on hospital readmission rates, measures of chronic disease management, assessment of quality improvements and clinical outcomes, and estimates of cost savings. Virginia will adopt those measures to determine the success of the Behavioral Health Home Pilot project.