



Your Extended Family.

New Mexico Legislative Finance Committee
Behavioral Health System: Opportunities to Improve Services and Address Service Gaps
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The Underserved's Extended Family for Over 30 Years



Founded in 1980 by Dr. C. David Molina

Single clinic

Commitment to provide quality healthcare to those most in need and least able to afford it

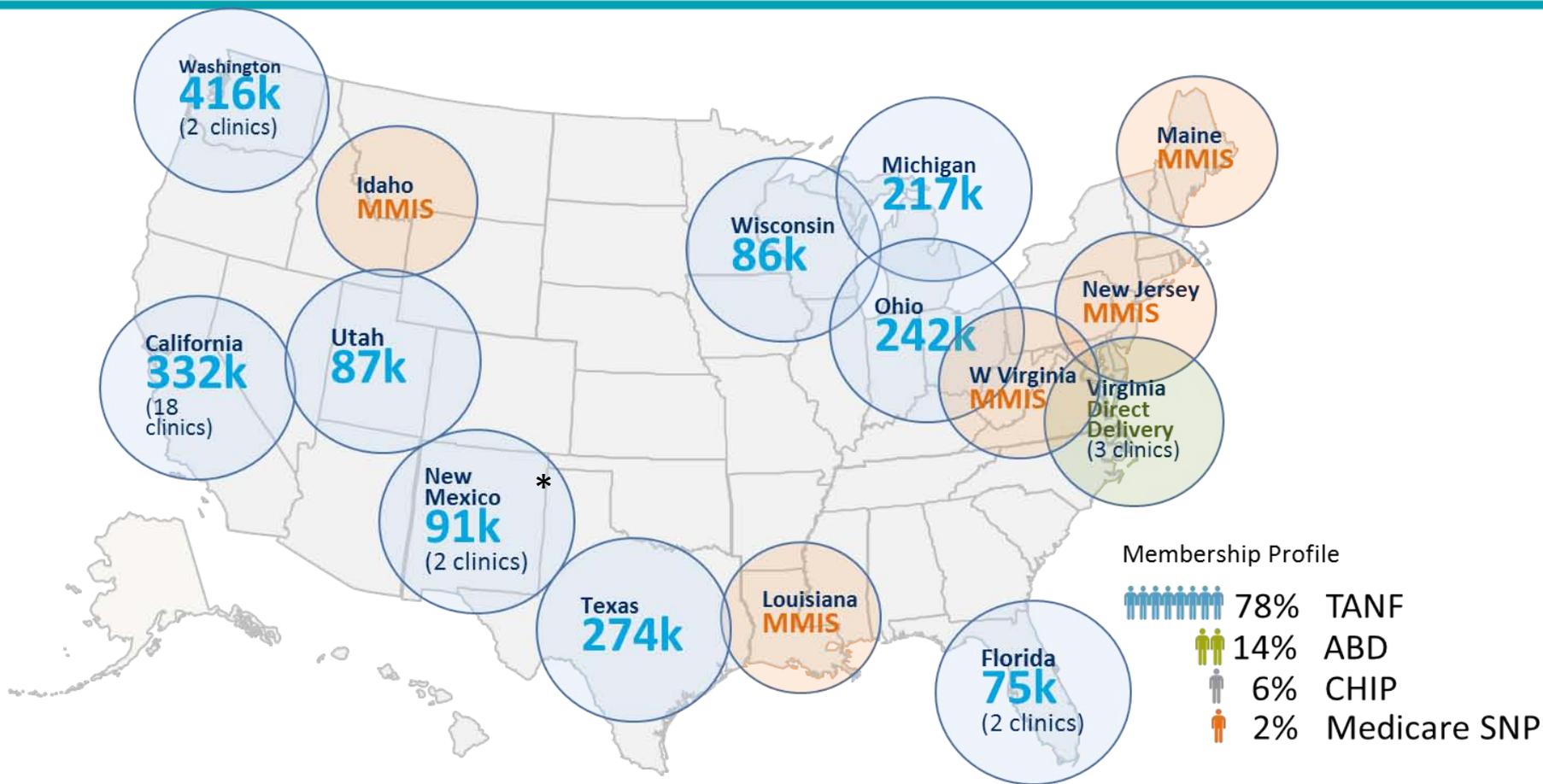


Fortune 500 company that touches over 4.3 million Medicaid beneficiaries

15 states

Business Snapshot

Our Markets (1Q2013)



1.8 million members

* 'Molina announced after the close on July 3rd, plans to assume Lovelace Community Health Plan's contract for the New Mexico Medicaid program. Financial details were not disclosed although management expects to complete the transaction on August 1, 2013. Lovelace serves approximately 84,000 Medicaid members in NM.'



To provide quality health services to financially vulnerable families and individuals covered by government programs.

History of Molina

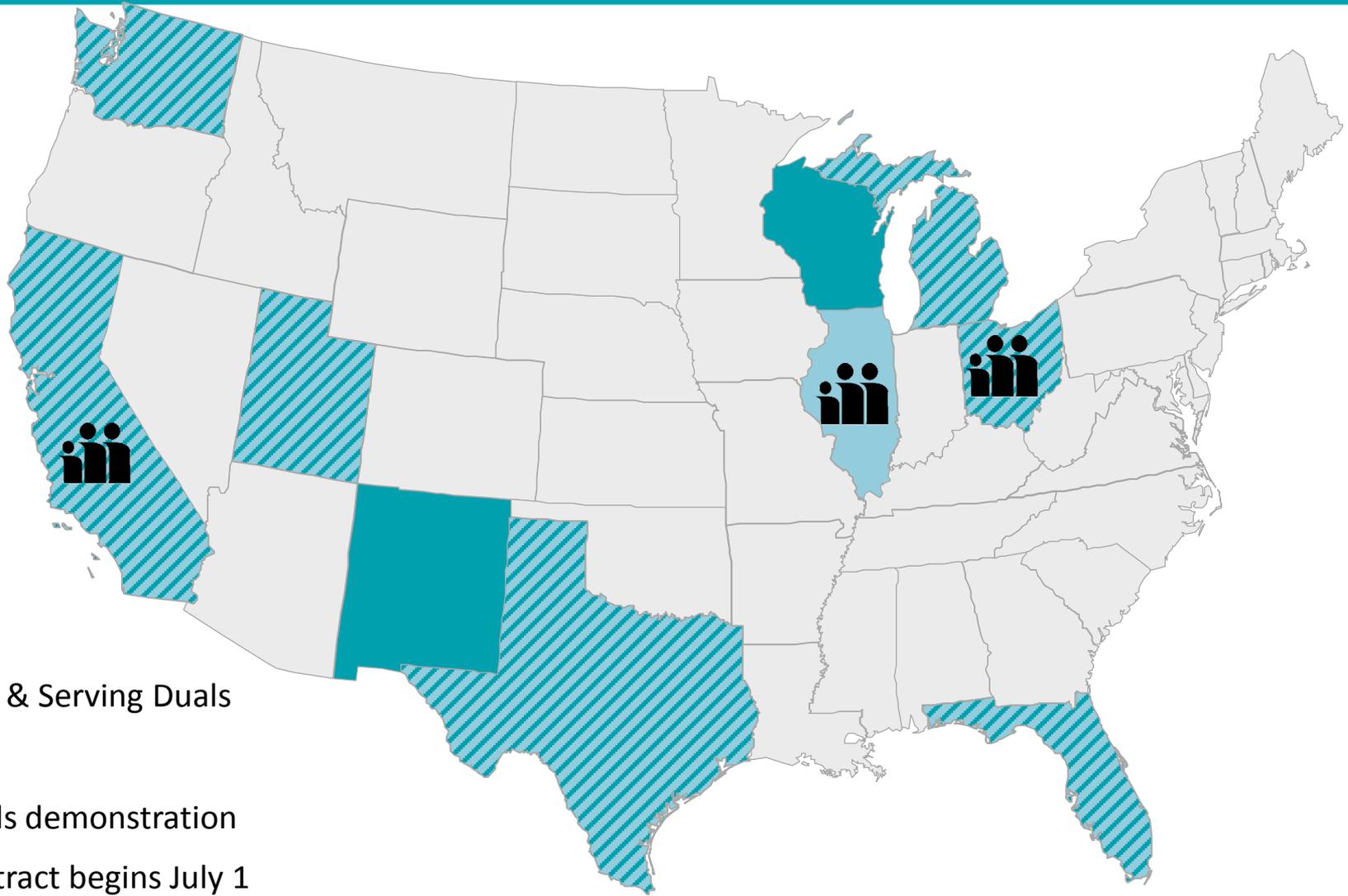


"Everyone deserves respect.
When they're down on
their luck, they need it more."

C. David Molina, MD



National ABD and Duals Focus and Commitment



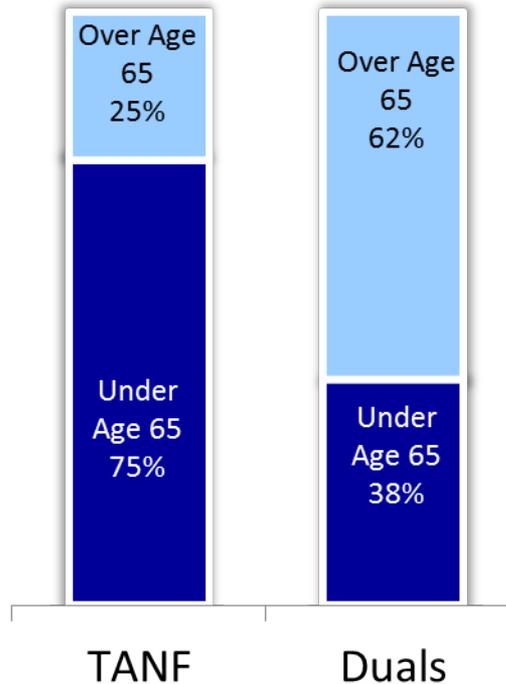
-  ABD & Serving Duals
-  ABD
-  Duals demonstration
-  Contract begins July 1

Two Ends of the Continuum

TANF

- Breaks in eligibility
- Episodic care
- Pregnancy
- Greater ethnic diversity
- Larger support system at clinic visits

Demographics¹



Duals

- More continuous eligibility
- Chronic illnesses
- Behavioral health
- More likely to have greater limitations in activities of daily living (ADL)
- Require more focused care including home care
- More likely to have a usual source of care and less likely to delay care due to cost

TANF

ABDs

Duals

Most Common Diagnoses

TANF Diagnoses	ABD Diagnoses	Dual Eligibles Diagnoses
Inpatient Services		
Delivery	Affective psychoses	Affective psychoses
Complications of delivery	Septicemia	Septicemia
Other maternal complications	Schizophrenic disorders	Care involving use of rehabilitation procedures
Prolonged pregnancy	Chronic bronchitis	Pneumonia
Other OB	Pneumonia	Chronic bronchitis
Outpatient Services		
Well Child care	Respiratory & other chest	Essential hypertension
Acute upper respiratory infection	Fever and fatigue	Respiratory and other chest
Respiratory & other chest	Diabetes mellitus	Diabetes mellitus
Fever and fatigue	Back disorders	Fever and fatigue
Ear infection	Joint disorders	Joint disorders

Medicare Benefits

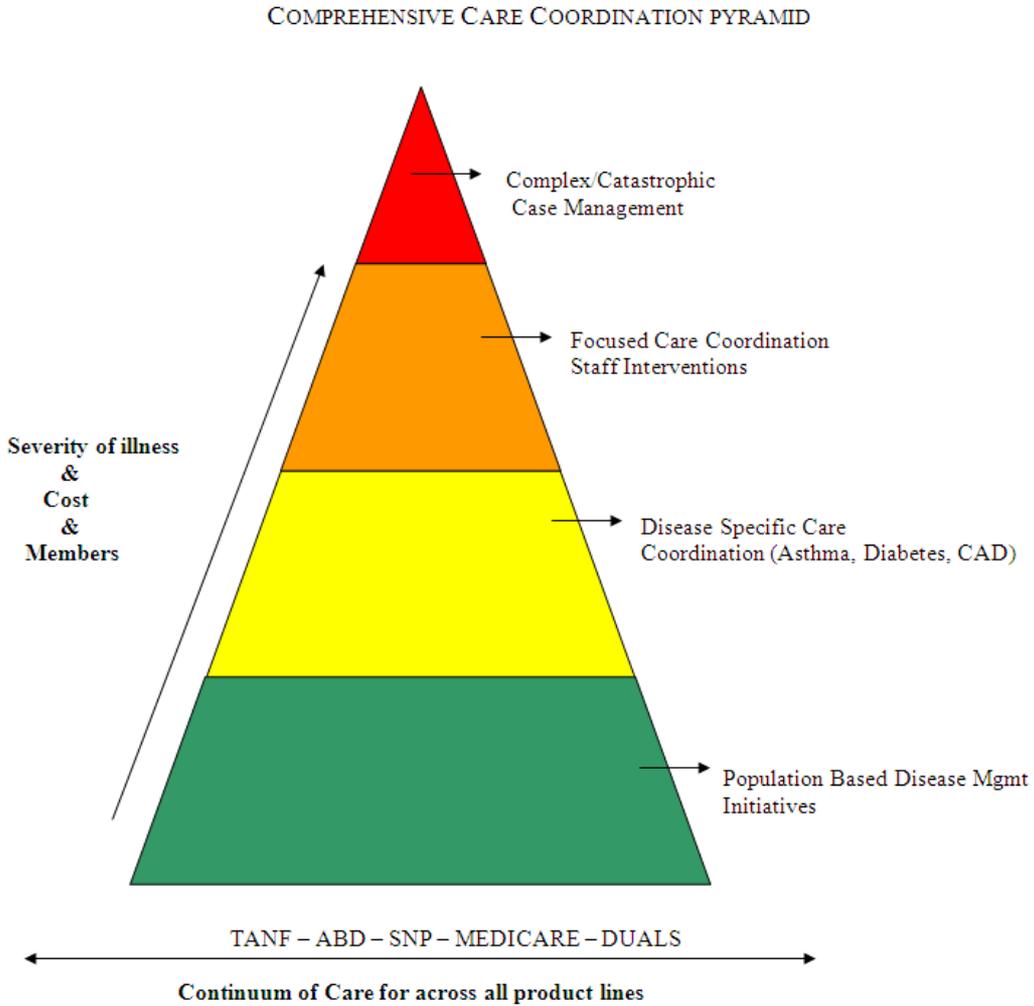
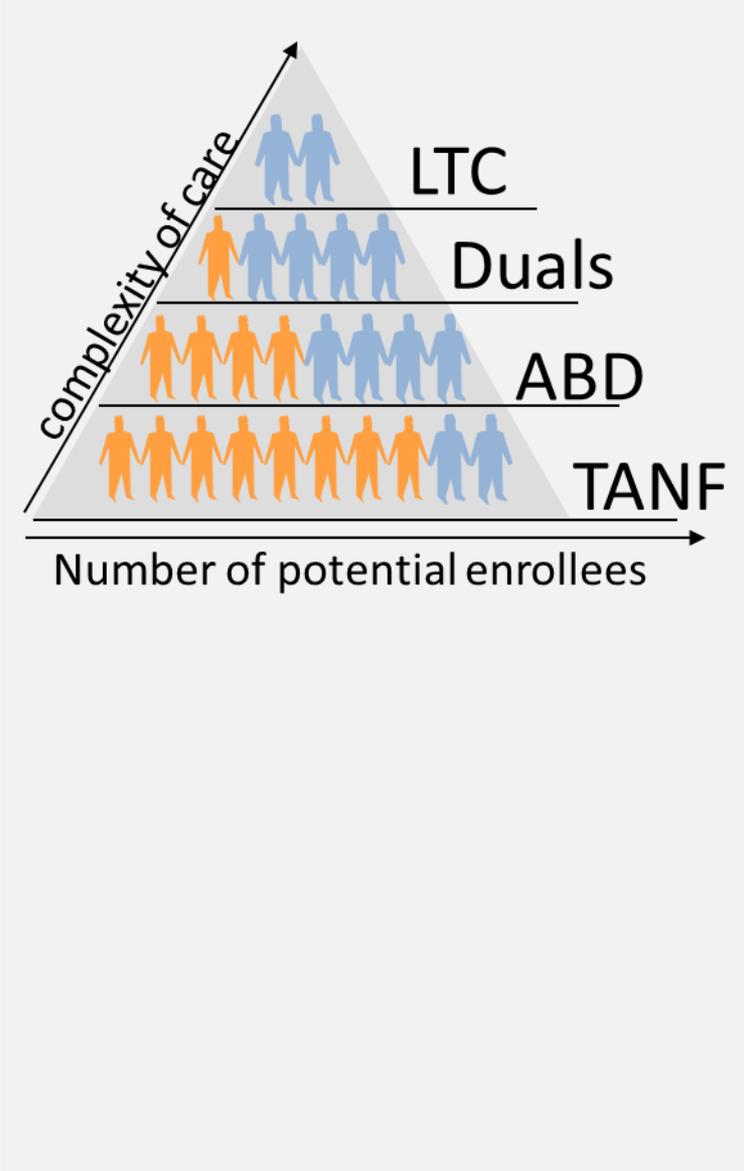
- Hospital Insurance (Part A)
 - Blood, home health care, hospice care, hospital inpatient stay, mental health inpatient stay, skilled nursing facility stay
- Medical Insurance (Part B)
 - Blood, clinical laboratory services, home health services, medical and other services, outpatient mental health services, outpatient hospital services, other covered services
- Medicare Prescription Drug Coverage (Part D)

Medicaid Benefits*

- Copayments for Medicare services
- Long Term Care
 - Institutional
 - HCBS (Home & Community Based Services)
- Personal Care
- Adult Day Care
- Home modifications
- Meals
- Paramedical/nursing services
- Physical, speech, and occupational therapies
- Behavioral health

*Subject to state carve-outs

Sources: KFF.org, "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded By CMS" and Medicare.gov, "Medicare costs at a glance"



Proactive, early engagement with members

Data driven prioritization of high risk members

Experienced case managers utilizing high touch model

Full engagement with community based service providers

ICT involvement by leading network providers in the area

Individualized goals that are specific and attainable

Automated, well documented Individualized Care Plan that is easy to share

Longitudinal coordination of care with case manager as single point of contact

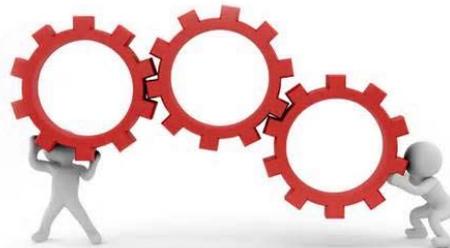
New Mexico presence and local relationship building experience

Best practices with over 30 years of national experience caring for the most vulnerable



In line with Molina's mission and principles of Centennial Care the focus of behavioral health services (BHS) is to:

- Provide culturally competent person-centered care
- Ensure coordinated services to address medical and behavioral health needs
- Offer models and several levels of integration of care
- Engage members in directing their care through personal choice
- Collaborate with providers through assisted communication
- Facilitate linkages through peer support and community based services
- Ensure administrative simplicity, quality of care, & fiscal responsibility



Demographics

Rich Multicultural Panorama

- NM population 2010: 2,060,971 (about 2% increase from 2009)
- 42% are White, 41% Hispanic, 11% Native American, Black or African American 3%, Asian or Pacific Islanders 2%.
- One of the poorest States in the U.S. ($\frac{1}{4}$ of the population is covered by Medicaid Program)
- Poverty levels are highest among minority populations
- Highest percentage of Hispanics in the U.S.
- 22 Different tribes and Pueblos
- Frontier 10%
- Rural 40%
- Urban 50%



Behavioral Health Issues in New Mexico

Behavioral Health by the Numbers

- New Mexico leads U.S. statistics in deaths from drug overdose
- 200,000 abusers of illicit or prescription drugs
- 25,000 are injection drug users
 - 11,000 untreated Heroin and Opioid addicts in Bernalillo County alone
- New Mexico has one of the highest suicide rates in the U.S.



Behavioral Health Service Gaps

2002 New Mexico Behavioral Health Gap analysis

- Crisis services
- In-home and wrap-around services
- Integrated services for persons with multiple or co-occurring needs
- Mental health and substance use services for youth
- Services for adults with behavioral health needs transitioning from prisons and jails
- Consumer and family-operated services
- Intensive outpatient services
- Culturally specific services for American Indians, new immigrants, and monolingual Hispanic individuals and families
- School-based behavioral health clinics and services
- Supported employment and housing for adults

* New Mexico Behavioral Health Gaps (2002)



Centennial Care Principles:

- Provide a comprehensive delivery system;
- Ensure personal responsibility;
- Implement payment reforms; and
- Ensure administrative simplicity.



Care Coordination

Care Coordination is a Centerpiece of Centennial Care

Molina Healthcare will be responsible for assuring that each member receives care that addresses a comprehensive biopsychosocial approach and will leverage a high touch and face-to-face model to achieve this.

There are 3 Levels of Care outlined in Centennial Care:

Level 1

- Least complicated members (*low Behavioral Health and low Physical Health*)
- Health Risk Assessment (HRA) is required

Level 2

- Intermediate level (*high Behavioral Health or high Physical Health*)
- Health Risk Assessment (HRA) and Comprehensive Needs Assessment (CNA) are required

Level 3

- Most complicated members (*high Behavioral Health and high Physical Health*)
- Health Risk Assessment (HRA) and Comprehensive Needs Assessment (CNA) are required

Quality of Care and Outcomes Goals

Improving Outcomes: Quality of Services Rather than Quantity

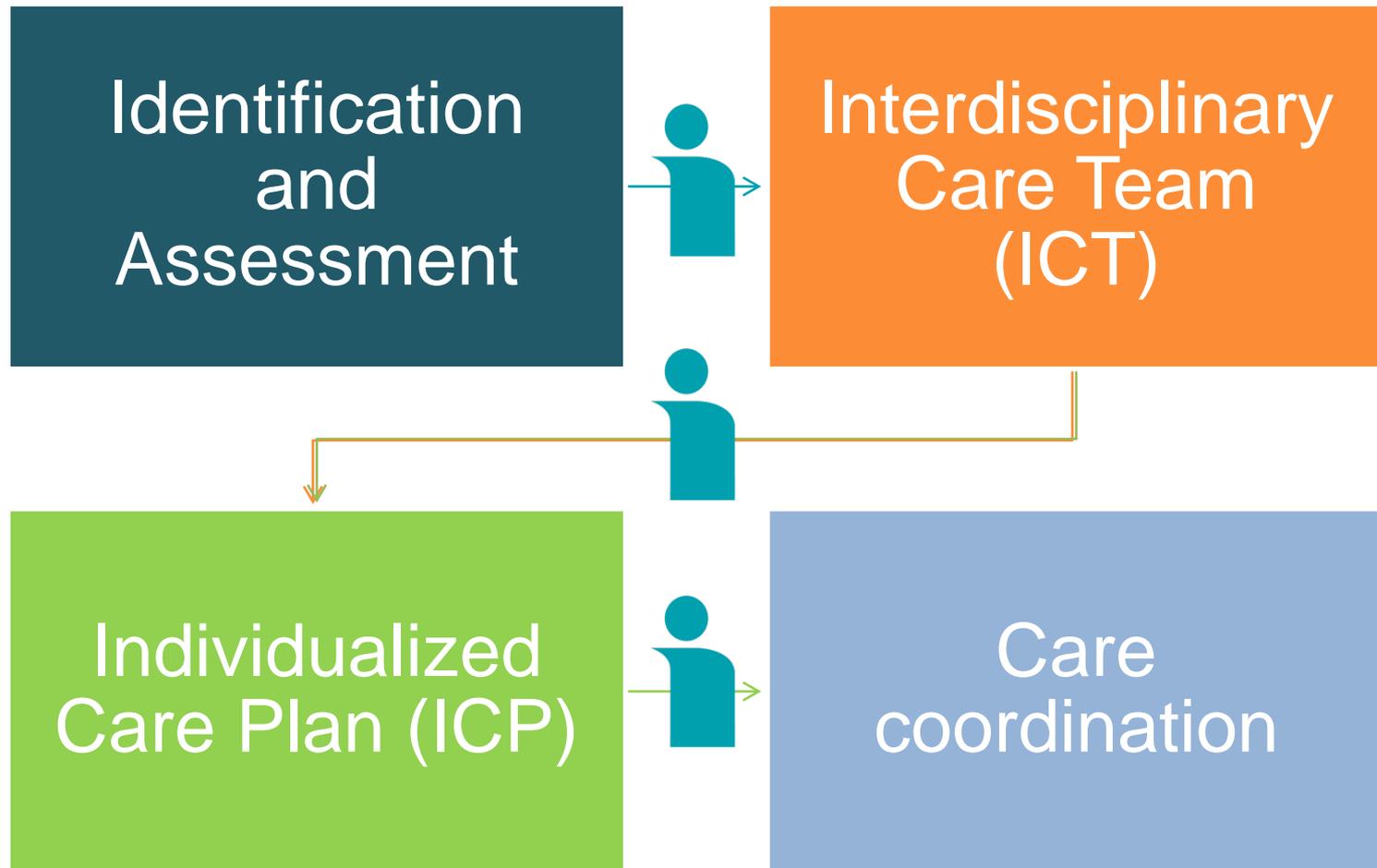
- Increase access (telehealth)
- Reduce variation of rates of consumers served vary across the state
- Improve consumer outcomes and reduce history of inconsistencies
- Improve outcomes of the drug dependent population to mirror those consumers with alcohol dependency
- Improve adequate access to follow up care within 30 days of inpatient discharge.
- Reduce costly service over-utilization



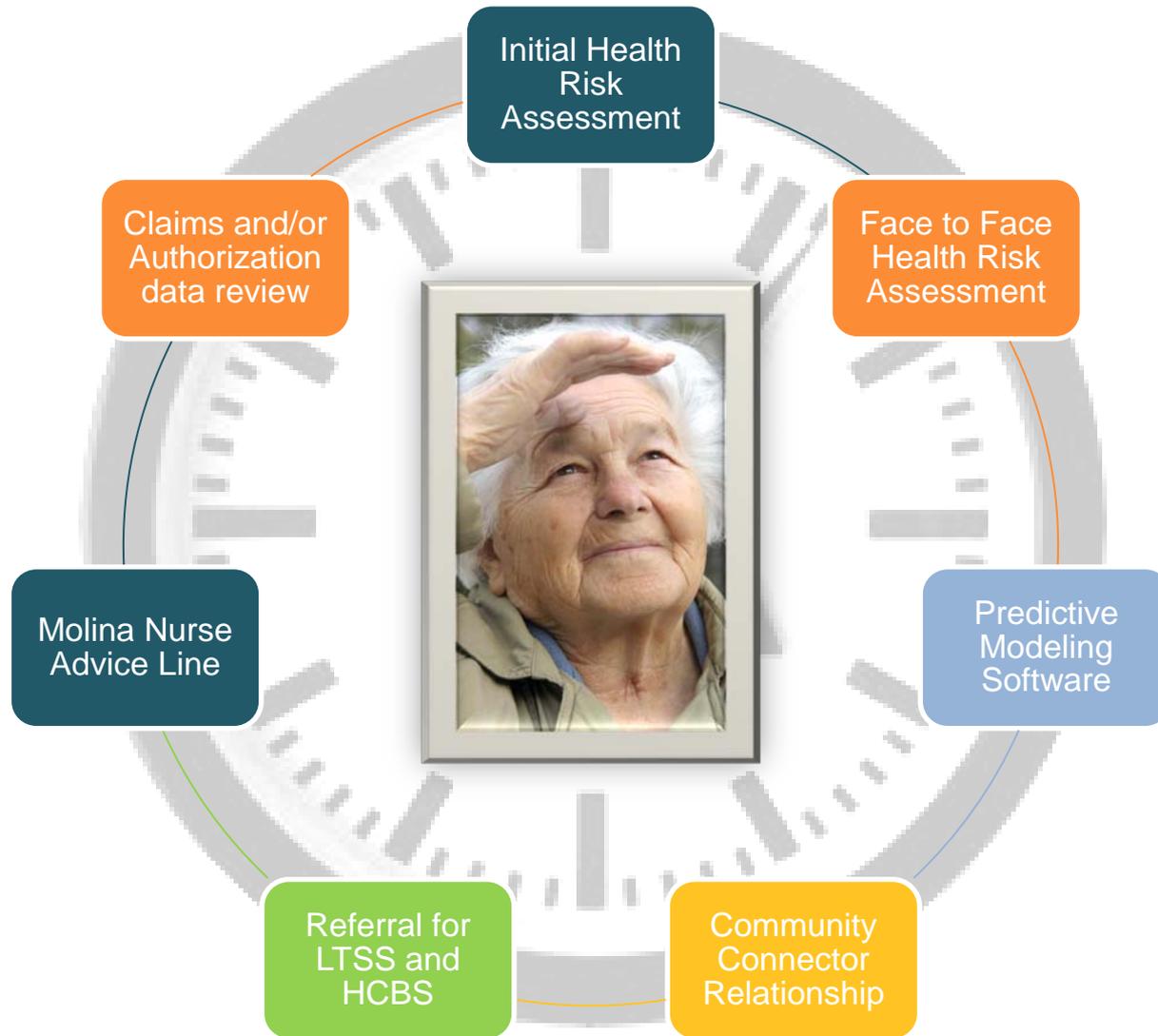
Quality Measures

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CHAPS)
- Mental Health Statistics Improvement Project (MHSIP)

- Test run claims, billing and payments
- Meet contractual requirements for both providers and the State
- Effective Treatment (evidence-based/ practice based)
- Recovery Oriented Systems Of Care
- Outcomes driven: Process versus Clinical Outcomes
- Ensuring the integrity of financial practices and delivering service and identifying in a timely fashion potential issues and problems
- Appropriate utilization practices: right amount of care in the appropriate setting
- Continue to build community-based services
- Emergency room diversion
- Open access (telehealth)
- Focus on successful treatments in NM and the development of pilot projects
- Culturally competent treatment
- Long term recovery housing.



Expediently Locating Henry and Laura



Case #1 Clinical Vignette Summary



Henry

Age/Gender

46 year old male

Diagnoses

Schizoaffective disorder, alcohol dependence, hypertension, diabetes

History

Psychiatric hospitalizations, involvement with public safety agencies, unstable housing situation

Status

- Working with Intensive Community Treatment team he is managing his mental illness, HTN and DM appropriately and consistently
- Sober with help from medication treatment, counseling and monitoring
- Stable housing through assistance and voucher program
- Ongoing community based wrap around supports coordinated by ICT

Assessing Henry's Health and Welfare Status

Based on pre-enrollment data and stratification, Henry would qualify for level III- complex case management and be assigned to a case manager at Molina's New Mexico plan.

Molina's Case
Manager reviews
available data



HRA completed
in person

Interdisciplinary Care Team - Henry's Support Team

Who

Case Manager
 PCP
 Network Behavioral Health Specialty Provider
 Community BH Provider
 Molina Clinical Pharmacist
 Molina Community Connector
 Additional ICT attendees per Henry's needs and preferences

How

Formal ICT teleconferences
 Close communication between Behavioral Health providers and PCP (as approved by Henry)
 Molina community connector home visit results communicated to ICT
 Case manager written and phone communications to coordinate care between ICT participants

The Molina case manager is a single point of contact for the member and coordinates all ICT activities

What

Fully developed and actionable Individualized Care Plan
 Integration of behavioral health and medical providers
 Safe and stable environment

Individual Care Plan - Henry's Path to a More Healthy Life

Care for his schizoaffective disorder

- Regular follow-ups with a Psychiatrist and case manager
- Appointment scheduling and transportation assistance
- Monitoring adherence to psychiatric medication regimen.

Care for his chronic alcoholism

- Substance abuse outpatient maintenance therapy
- Access to and adherence with his Vivitrol regimen.

Ongoing care for his hypertension and diabetes

- Insulin and diabetes/nutrition education
- Monitoring for adherence to diabetes and hypertension medications
- Consider integrated Medical and Behavioral Health setting

Monitor housing situation

- Maintenance on community based vouchers or other community housing assistance.
- Monitor for eligibility for other waiver or community based enhanced benefits

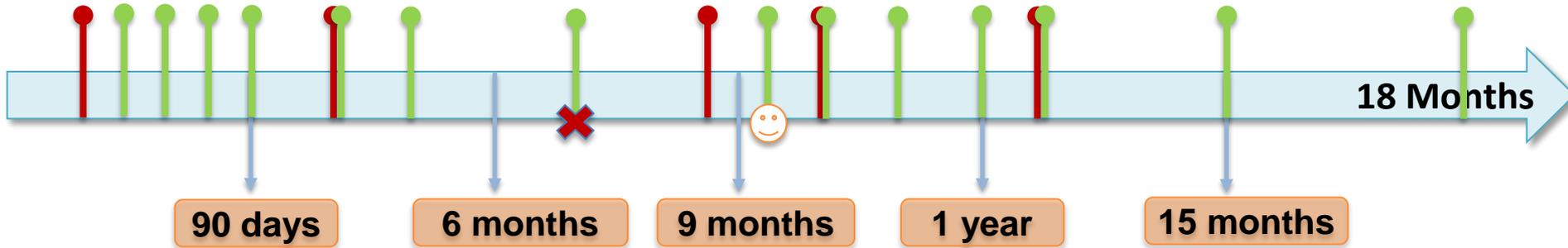
Care Transitions process for acute episodes

- Case manager provides hospital discharge support
- Support from the Community Connector program

Molina's Medication Therapy Management Program

- Individualized clinical pharmacist consultation and medication review/reconciliation

Improving Henry's Health, Safety, and Welfare: Touch points



High touch and proactive approach to Henry's health safety and welfare

Constant screening for change in Henry's health status

Our Managed Healthcare Assets

- #1 Medicaid Health Plan in New Mexico (NCQA)
- Molina's emphasis on cultural competency
- Understanding of current socio-demographic trends
- Molina experience with integrated care
- Largest Hispanic owned business in U.S.
- Collaboration with Native American communities
- Experience with traditional Hispanic and Native American healing practices
- Collaboration with Center for Native American Health (CNAH)
- Extensive community outreach and engagement





Case #2 Clinical Vignette Summary

Age/Gender

68 year old female

Laura

Diagnoses

Diagnoses include multiple sclerosis, falls, history of Methicillin Resistant Staph Aureus (MRSA) and skin integrity issues

History

History of multiple transitions between home, hospital (3 Admits), ER, Skilled Nursing Facilities (3 Admits, >230 Days), unstable housing, home health needs, home safety issues, personal care, significant mobility issues, limitations on activities of daily living (ADL), social isolation, major economic difficulties impacting shelter and potentially nutrition and medication, lack of support system

Status

- Continued decline of health and stamina
- Medication affordability and ability to find affordable housing are ongoing major challenges to address
- Current living situation is a nursing facility. Laura desires to return to work and to live in the community

Assessing Laura's Health and Welfare Status

Based on pre-enrollment data and stratification, Laura would qualify for level III – complex case management – and be assigned to case manager at Molina's New Mexico plan. She was borderline level IV, but was placed in level III due to the stabilized environment of the Skilled Nursing Facility.

Molina's Case
Manager reviews
available data



HRA completed
in person

Individual Care Plan - Laura's Path to a More Healthy Life

Care for her multiple sclerosis

- Including regular follow-up with a neurologist for management of her MS
- Evaluation of the adequacy of current treatment regimen for MS.

Care for her debilitated physical condition

- Including physical therapy and home exercise programs as appropriate
- Consideration of PT/OT referral for home safety assessment and evaluation of needs.

Care for decubiti and skin integrity

- The need for continued MRSA treatment if the patient were to transition to a home setting for care.

Care for nutrition needs

- Eligibility for community based or medical nutrition enhancement through her medical benefit
- Coaching from Integrated Case manager.

Care for safety and mobility needs

- Adequacy of current motorized wheelchair
- Home modifications within a potential home environment to enhance safety at home.

Use of transportation benefit

- To enhance mobility in the community

Transitional planning and evaluation

- Identification of multiple needs for; personal care and home care, community housing, socialization and financial assistance for food services, and accessible housing

Transitions of care interventions

- Deployed to develop and closely monitor appropriate discharge plans after acute hospitalization
- Use of the Community Connector program to perform regular home based follow-up with the Laura.

Review of medications

- By clinical pharmacist as part of MTMP Program
- To determine efficacy and cost effectiveness of current medication regimen.

Behavioral health assessment

- Screen for depression
- Evaluate her ability to live independently.

Interdisciplinary Care Team - Laura's Support Team

Who

Case Manager
PCP
Network Specialty Providers (Neurology or Physical Medicine and Rehabilitation)
Network Skilled Nursing Facility Staff
Network Physical Therapist
Network Behavioral Health Specialist
Network Home Health Agency
Network Dietitian Specialty Provider
Molina Clinical Pharmacist
Molina Care Transitions Staff
Molina Community Connector
Out of Network Providers or Facility Staff
Molina Medical Director

How

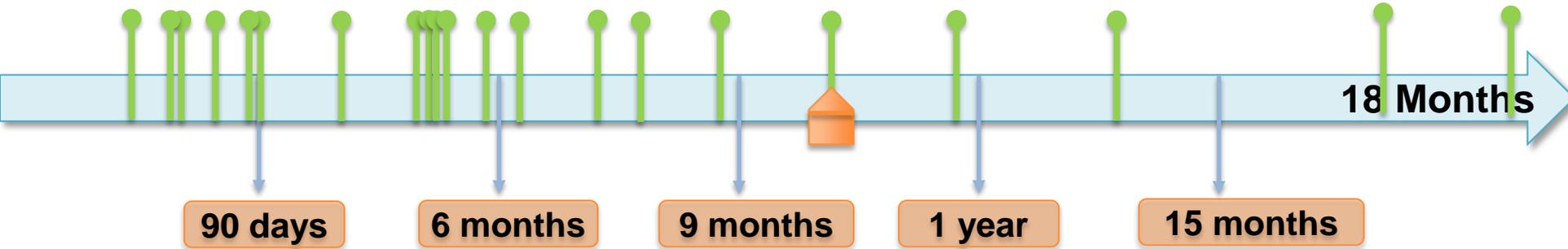
Formal ICT teleconferences
Case manager attending SNF rounds
Molina community connector home visit results communicated to ICT
Case manager written and phone communications to coordinate care between ICT participants
Care transitions team written and phone communications to coordinate care during transitions

What

Fully developed and actionable Individualized Care Plan
Successful member-centric transition plan

Molina's case managers have implemented best practices and lessons learned from national duals experience to help facilitate communication among all ICT participants

Improving Laura's Health, Safety, and Welfare: Touch points



Laura is engaged at every opportunity

Molina supports Laura's health, safety and welfare in the least restrictive environment