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How an obscure Obamacare provision is quietly saving lives, and money, in Missouri

By Sheree Crute Washington Monthly Mar 21, 2017

Doctor

Dr. Joe Parks

Dr. Joe Parks serves as the Director of MO HealthNet, Missouri's Medicaid authority in Jefferson City, Missouri. He also holds the position of Distinguished Research Professor of Science at the University of Missouri - St. Louis

About a decade ago, Pat Powers' life began to spin "out of control," as she puts it. Powers, a soft-spoken Missouri native, was stressed out from working at Walmart and two other part-time jobs to make ends meet. She was also suffering from diabetes and severe anxiety and depression.

Powers found her way to Crider Health Center in St. Charles, a federally funded community health facility that provides a host of physical and mental health services to Medicaid patients such as Powers, all under one roof.

There, a psychiatrist, realizing that Powers could not juggle multiple jobs and hope to get better, got her onto disability as he worked to stabilize her mental health issues. A physician also prescribed medication for her diabetes.

Yet despite the treatment, Powers still couldn't tame what she called her "nervous breakdowns" — emotional storms that left her seeking help in Missouri emergency rooms. While she fought to regain her emotional stability, her diabetes only got worse.

The problem was that the care Powers was receiving wasn't well-coordinated, and she wasn't receiving the guidance and support she needed. Her psychiatrist and the doctor treating her diabetes weren't communicating sufficiently, and no one knew whether she was taking her prescribed medications (it turns out that she wasn't, at least not regularly).

The management at Crider, which is part of the Compass Health Network, was aware of the lack of coordination, and like thousands of health care professionals around the country, they were seeking ways to fix it.

But like any facility trying to survive on Medicaid's penurious reimbursement rates, the funding wasn't available to do much more. Meanwhile, the lack of investment in coordination was, ironically, costing taxpayers a bundle.

In 2011 alone, Powers racked up more than \$10,000 in care, primarily in emergency rooms.

Powers is a member of a group with a dubious distinction: the "5/50" population, short for the 5 percent of patients who account for approximately 50 percent of the nation's health care costs. These are people who typically suffer from two or more chronic, complex health conditions. Many are elderly. Some, like Powers, also have mental health issues that make treating their physical ailments especially challenging.

"They could be hearing voices, they could be in a manic phase and not be able to focus," Pam Haynes, a nurse care manager at Crider says of her patients. "Some people don't understand, for example, that a piece of paper they are given by a doctor is a prescription and that you actually take that to a pharmacy. ... [They] might go back to the hospital in three days and say, 'I'm still having the same problem. What am I supposed to do?'"

Things began to turn around for Powers in 2012. That's when Crider and 25 other community mental health centers around Missouri began to receive two years of enhanced federal funding as part of Medicaid's Section 2703, a provision of the Affordable Care Act.

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Section 2703 grants help health care providers defray the costs of becoming “health homes” — that is, organizations that offer a range of carefully integrated services, including clinical and behavioral health care, along with supportive social services — care thought to be particularly effective for high-need, high-cost patients such as Powers. Crider used its share of the funds to, among other things, hire and train nurse managers to help patients set goals and guide their care.

It also brought in integrated care managers to help all of the health home’s various care providers — and often outside social service agencies — work in concert for every patient. Those social services might include home visits, and support addressing tough issues like homelessness, unemployment, and social isolation.

In Powers’ case, health home care involved sharing information about her medications, hospitalizations, diet, diabetes management, and even employment and housing status. “Like a lot of my clients here, she struggled with basic things, like ‘What’s a carbohydrate’ and how to eat for her diabetes,” says Mary Puetz, the dietician on Powers’s team.

By working together, the team helped Powers lower her A1C (a measure of blood glucose) from a dangerous 9.0 to a more manageable 7.4 (6.5 is considered normal) and her cholesterol from 210 to 172.

“They helped me understand my depression and cope with things that I stress on, and they helped me with my weight control and diabetes,” says Powers. “Now I’m taking my medication ... and I lost 10 pounds.”

They also helped her find a part-time job. Now, instead of showing up at emergency rooms, she shows up to work the buffet at a local restaurant. “I feel better about myself,” she says with evident pride. “I know I can handle any situation I come across.”

The 2703 program is one of the many types of care delivery and payment reform buried in the law known as Obamacare, and it has been notably successful in improving patient outcomes while driving down health care costs in many states. Yet as congressional Republicans and the Trump administration try to make good on their promise to “repeal and replace” the Affordable Care Act — ostensibly because of its high cost — the 2703 program is at no small risk of getting wiped out.

More integrated approach

The idea of coordinating care for better results is hardly new. The concept dates to at least the 1960s, when some pioneering physicians became concerned that ever-increasing medical specialization and the growth of complex chronic diseases among the elderly required a more integrated and scientifically driven approach to health care. These physicians organized the first large-scale health maintenance organizations (HMOs), in which primary care doctors would coordinate care in large, multi-specialty medical group practices that would be part of a system of hospitals, labs, and pharmacies. But the HMO experiment largely fizzled out, and numerous other attempts to encourage integration also failed to take off. One reason is that most health care payment systems, be they private insurance companies or government programs like Medicare, make it difficult for providers to be reimbursed for much of the work — like home visits and coordination meetings — that integrated care typically requires. Another obstacle is cultural: organizations are hard to change, and doctors, nurses, and other health care providers were trained to work in silos. The level of care integration — or “wraparound care,” as some experts call it — is a challenge to achieve.

Health care professionals in Missouri understood the need for integrated care, especially after a 2006 report by Joe Parks, a researcher and the current director of MO HealthNet, a division of Missouri’s Department of Social Services, showed that patients with serious mental illness were dying 25 years earlier than the rest of the population.

“They were dying of things we could help with — chronic health problems,” recalls Nancy Gongaware, a senior vice president of outpatient health care at Missouri’s Compass Health Network, “but we needed to develop a new way of taking care of them.”

Among other things, Missouri health care officials arranged for primary care doctors, dentists, and psychiatrists, along with social workers, dietitians, and others, to be located in the same building so that patients could have “one-stop shopping” for all their health care needs.

But just because these professionals worked under the same roof did not guarantee that they would work together. They were neighbors, but not yet teams.

The opportunity to go further came when Barack Obama signed the Affordable Care Act in 2010. Missouri, under then Gov. Jay Nixon, was one of the first six states to apply for the ACA’s new 2703 grants. Eventually, 19 states, including the District of Columbia, would do the same.



For years, health policy experts have known that “a lot of the expense in health care comes from poor care coordination,” says Cheryl Damberg, who studies payment reform for RAND.

The ACA established policies supplying billions of dollars that fast-tracked experiments in new and better ways aimed at comprehensive health care, while achieving savings through that improved care.

According to a review by the Missouri Department of Mental Health, the results of the 2703 grant program in that state have been impressive. The more than 23,000 Missourians who have received care under the health home initiative met or exceeded six of nine benchmark goals for disease management after the ACA-supported expansion. For patients with diabetes alone (America’s most costly disease, at approximately \$332 billion a year), the number with controlled blood glucose levels rose from 18 percent to 61 percent. The percentage of patients with hypertension and cardiovascular disease who controlled their blood pressure went from 24 to 67 percent, and their good cholesterol levels soared from 21 to 56 percent.

On the cost side, hospitalizations and emergency room visits for this group dropped 14 percent and 19 percent respectively. This saved the state \$31 million just in the first year of the program, and the savings have continued, according to Natalie Fornelli, manager of integrated care at Missouri’s Division of Behavioral Health.

In 2015, Missouri’s health home program won the American Psychiatric Association’s Gold Achievement Award for community health services. The program is now considered a national model.

If there is a downside to the health home initiative, it is that too few Missourians benefit from it. That’s largely because of the politics of Obamacare. While Nixon, a Democrat, had the statutory ability to request the 2703 grant funds, and did so aggressively, Missouri’s GOP-controlled Legislature adamantly opposed accepting federal Medicaid expansion funds under the ACA. As a result, 632,000 Missourians remain uninsured, including 40 percent of the 1 in 10 Missouri residents with serious mental illness.

That situation is unlikely to change anytime soon, unless Missouri’s new Republican governor, Eric Greitens, who replaced term-limited Nixon in January, can convince his legislators to change course — an uphill climb at best.

Last April, the Legislature went in the opposite direction, passing a bill requiring Medicaid recipients to pay an \$8 copay for any ER visit that is not deemed an emergency, or any missed doctor’s appointment. Nixon vetoed the law in July. It will go to Greitens next.

At the national level, the fate of the 2703 program is also in doubt. It’s possible that, as Republican lawmakers in Washington and the Trump administration wrestle with the complexities of repealing and replacing Obamacare, they’ll conclude that failing to continue the 2703 grants will likely cost more in tax dollars than it saves, even as it would deprive hundreds of thousands of poor, mentally ill Americans the coordinated treatment that can save their lives. But, as Sidney Watson, a professor at the St. Louis University School of Law and an expert on health care access for the poor, observes, Trump’s new Health and Human Services secretary, Tom Price, “has expressed a lot of skepticism about the Medicare and Medicaid demonstration centers.”

Still, the advances made at places like Crider Health Center are real and ongoing, even if, without more 2703 grants, they’re unlikely to spread to other community mental health centers. The improved care at Crider has certainly done a world of good for patients such as Powers. “Without it,” she says, “I wouldn’t be here. I’d be gone.”

Sheree Crute is a health policy writer based in Brooklyn, and the author of “Health Insurance, a Brief History: The Impact of Obamacare.” [This story appears in the current edition of The Washington Monthly.](#)

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