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INSIGHT

An Information Resource from COMCARE

Proposed New Mental Health Program – Reach Out PA

Governor Tom Wolf announced on January 2, 2020 a focused multi-agency effort and anti-stigma campaign, 'Reach Out PA: Your Mental Health Matters,' aimed at expanding resources and the state's comprehensive support of mental health and related health care priorities in Pennsylvania. The governor announced several initiatives and reviews the administration will undertake for commonwealth agencies to bolster the effort. The governor was joined by mental health advocates, social workers, educators, military veterans, and cabinet secretaries in making the announcement.

"For those struggling with their mental health, we have one message: your mental health matters and it's okay to reach out for help," Gov. Wolf said. "We are stepping up our efforts to ensure every Pennsylvanian can access mental health care and more agencies can respond to the challenges facing Pennsylvanians struggling with their mental health."

Strengthening Mental Health Care Access

The Pennsylvania Insurance Department (PID) will pursue Mental Health Parity regulations to ensure Pennsylvanians' health insurance coverage provides access to affordable mental health care. Recent market conduct reviews by the PID found…

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…that insurance companies are not adequately meeting federal and state requirements for mental health parity, necessitating stronger state regulations. PID also will release educational tools to help patients better understand their mental health benefits and access services.

The Department of Human Services will take steps to incentivize the integration of physical and behavioral health services to remove barriers to coordinating care and treatment. DHS will create financial incentives to encourage managed care organizations that provide Medical Assistance benefits to create, maintain, and continuously improve collaboration between the entities and providers that coordinate and deliver physical health benefits and mental health benefits.

The Department of Health will conduct a review of the current network adequacy process to ensure that consumers enrolled in the Medicaid program and commercial insurance products are able to access mental health care providers when services are necessary and without prohibitive costs.

The departments of Labor & Industry and State will study solutions that address the inadequacy of the mental health workforce across Pennsylvania, including evaluating mental health practitioners across the commonwealth by level of care they provide, the competitiveness of salaries and benefits, and barriers of entry to the workforce.

Combatting Mental Health Stigma
Many Pennsylvanians do not access the mental health care they need or do not reach out for help because they fear having a label or stigma attached to them by their family, friends, and community. By raising awareness of the normalcy and importance of mental health care, others will be less fearful of the stigma. Pennsylvania's nationally recognized response to the opioid and substance use disorder crisis included public engagement and open conversations to combat stigma. The Wolf administration will deploy the practices used by the Department of Drug and Alcohol Programs to lead a similar effort around mental health and mental illness.

Reach Out PA will include roundtable discussions to hear directly from those battling the stigma of mental illness, collaboration with community-based organizations to help increase public attention on mental illness and mental health care, and outreach to elevate success stories and best practices.

Increasing Support and Proactive Resources for Children and Young Adults
The Department of Education will create pathways to increase the number of highly qualified social workers trained to work in our schools. School social workers play a unique role in addressing mental health by providing holistic services and supports in the school setting, such as crisis management, mental health treatment, and engaging the school, family and community in enhancing existing student support structures that ensure the success of all students. Pathways will include new certification, among other options, to enhance who can provide social work services in Pennsylvania's schools.

The Department of Education and the Pennsylvania Commission on Crime and Delinquency will evaluate how to ensure every school district can provide a full-time counselor, social worker and nurse, along with increasing more counseling and mental health services at post-secondary institutions.

The Office of Advocacy and Reform will coordinate and expand upon ongoing efforts in the commonwealth to address Adverse Childhood Experiences (ACEs) and implement more trauma-informed approaches in education, health care, the criminal justice system and other government institutions.

Preparing State Agencies and Workers to Help and Reach Out
The administration will expand training of constituent affairs personnel on suicide prevention and mental health intervention. To date, more than 420 workers at the Department of Labor & Industry have received suicide prevention training. With this training, workers have already been able to recognize people who need help with their mental health, to intervene and connect them… *Continued on Page 3*

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…with services or support. The Department of Military and Veterans Affairs will educate members of the military and veterans on resources available to them, especially those struggling with Post Traumatic Stress Disorder and at risk for harming themselves or others.

The Department of Aging will expand its efforts to create a dementia-friendly Pennsylvania to support training, build awareness and promote action among community stakeholders.

"The steps I'm outlining today are just the beginning of what I plan to grow into a large-scale effort to combat mental health issues in Pennsylvania," Gov. Wolf said. "We've seen success with a multi-pronged attack against the opioid crisis. Reach Out PA will do the same with mental health."

Provided by Governor's Healthcare Press Release – https://www.governor.pa.gov/newsroom/pennsylvania-launches-reach-out-pa-your-mental-health-matters/; January 2, 2020

Muhlenberg Hosts First 'Reach Out PA: Your Mental Health Matter' Roundtable

Convened by Governor Tom Wolf with the help of Representative Mike Schlossberg '05, the discussion focused on how to increase access to and reduce the stigma of mental healthcare. Attendees included U.S. Congresswoman Susan Wild, Pennsylvania Health Secretary Rachel Levine and Muhlenberg Director of Counseling Services Tim Silvestri as well as other state and local legislators, public school administrators, city and state agency representatives and mental health service providers. "Our job must be to ensure that every single Pennsylvania resident who is searching for hope, for treatment, for love and for a better life can find it," said Schlossberg. "And that is why we are here today."

Excerpted from: Todaro, K.; https://www.muhlenberg.edu/news/2020/muhlenberghostsfirstreachoutpayourmentalhealthmattersroundtablediscussion.html; January 10, 2020.

Key Medicaid Policy Changes – Results of a 50-State Medicaid Budget Survey

Medicaid covers one in five Americans, accounts for one in six dollars spent on health care in the United States and makes up more than half of all spending on long-term services and supports. Medicaid is a state budget driver as well as the largest source of federal revenue to states. The program is constantly evolving in response to federal policy changes, the economy, and state budget and policy priorities. As states began state fiscal year (FY) 2020, the economy in most states was strong. With fewer budget pressures, many states reported expansions or enhancements to provider rates and benefits.

The Kaiser Family Foundation (KFF) and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors (NAMD) has recently conducted an in-depth examination of the changes taking place in Medicaid programs across the country. The findings are drawn from the 19th annual budget survey of Medicaid officials in all 50 states and the District of Columbia.

Key findings of this survey (including state-by-state details) provide details on:

- Medicaid Eligibility – expansions by 9 states in 2019, with an anticipated expansion by 20 additional states in 2020. Conversely, a number of states continue to pursue Section 1115 waivers which include policies that would result in eligibility restrictions in FY 2019 and FY2020. The most frequently reported eligibility restrictions implemented in FY 2019 or planned for FY 2020 are work or community engagement requirements.
- Delivery Systems – as of July 1, 2019, among 40 states with comprehensive risk-based manage care organizations (MCOs), 33 states reported 75% or more of their Medicaid beneficiaries were enrolled in MCOs. States continue to develop quality initiatives and exploring the use of other service delivery and payment reform models to achieve better outcomes and lower costs. 44 states had one or more delivery system or payment reform initiatives in place in FY 2019, with 14 states adding or expanding service delivery system reforms in FY 2020. (***See "Delivery System Reform Initiatives Defined" on Page 5***)
- Benefits and Cost-Sharing – the number of states reporting benefits expansions (23 in FY 2019 and 28 in FY 2020) continues to significantly outpace the number of states reporting benefit restrictions (4 in FY 2019 and 2 in FY 2020). The most common benefit enhancements reported were for mental health and substance use disorders (SUD) services. States continue to pursue strategies to control high-cost prescription drugs and to address the opioid epidemic.
- Long-Term Services and Supports – nearly all state in FY 2019 (48 states) and in FY 2020 (47 states) are employing one or more strategies to expand the number of people served in home and community-based settings. States continue to work to address

Notable:
Minimum Medical Loss Ratios

The Medical Loss Ratio (MLR) reflects the proportion of total capitation payments received by an MCO spent on clinical services and quality improvement. CMS published a final rule in 2016 that requires states to develop capitation rates for Medicaid to achieve an MLR of at least 85% in the rate year, for rating periods and contracts starting on or after July 1, 2019. Also, contracts taking effect on or after July 1, 2017 must include a requirement for plans to calculate and report an MLR. The 85% minimum MLR is the same standard that applies to Medicare Advantage and private large group plans. There is no federal requirement for Medicaid plans to pay remittances to the state if they fail to meet the MLR standard, but states have discretion to require remittances.

States were asked whether they require MCOs that do not meet the minimum MLR requirement to pay remittances. Twenty-four states reported that they *always* require MCOs to pay remittances (Pennsylvania is among this group), while six states indicated they *sometimes* require MCOs to pay remittances.

challenges finding and retaining LTSS direct care workers. States were set to phase out their "Money Follows the Person" (MFP) programs in federal FY 2020, but Congress provided additional funding for a short-term extension of the program. In FY 2019, Pennsylvania continued to phase in implementation of its Community HealthChoices (CHC) Managed Long-Term Services and Supports (MLTSS) program for dual eligibles, older adults, and individuals with physical disabilities. CHC is now statewide in FY 2020.

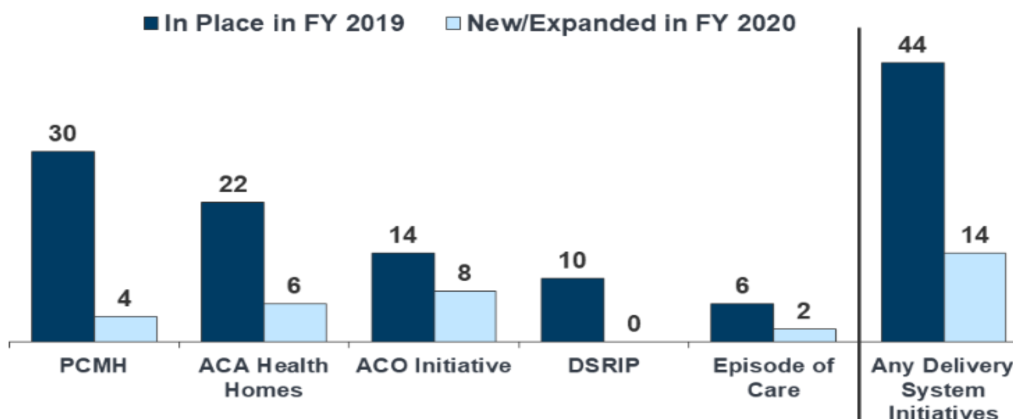
- Provider Rates and Taxes - a strong economy and state revenue growth allowed most states to implement and plan more fee-for-service (FFS) provider rate increases for FY 2019 (50 States) and FY 2020 (45 States). This holds true across all provider types, including inpatient hospital rates and nursing facility rates. As more states increasingly rely on capitated managed care, however, FFS rate changes are a less meaningful measure of provider payment unless states establish MCO payment requirements. Nearly half of the MCO states reported doing so: 19 states reported mandating minimum provider reimbursement rates in their MCO contracts for inpatient hospital, outpatient hospital, or primary care physicians and 17 states reported requiring MCOs to change provider payment rates in accordance with FFS payment rate changes for one or more of these provider types.

- Challenges and Priorities in FY 2020 and Beyond Reported by Medicaid Directors – states continue to administer and make changes to Medicaid programs focusing on payment and delivery system reforms, adapting to state budget and policy priorities as well as new federal Medicaid options. Over half of states reported that delivery system and payment reforms are a key priority. Nearly a third of states reported information technology (IT) systems projects currently underway or planned as high priorities. Consistent with past surveys, these projects often relate to Medicaid Management Information Systems (MMIS) procurements and eligibility system upgrades and replacements. One quarter of states reported that dealing with state Medicaid budget and fiscal challenges remained a top priority.

Emerging Delivery System Reform

Over three-quarters of all state Medicaid programs (44 states) had at least one of the specified delivery system or payment reform models in place in FY 2019, continuing the upward trend of state-led reforms that aim to address quality and costs. A recent Kaiser Family Foundation survey asked states whether certain delivery system and payment reform models... *Continued on Page 6*

State Delivery System Reform Activity, FYs 2019-2020



NOTES: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and other increases in enrollment or providers.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

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…were in place in FY 2019, and whether they planned to adopt or enhance these models in FY 2020. For FY 2020, 14 states reported plans to adopt or expand one or more of the models to reward quality and encourage integrated care. Key initiatives include patient-centered medical homes (PCMHs), ACA Health Homes, and Accountable Care Organizations (ACOs). The graph on page 5 shows the State Delivery System Reform activity for FYs 2019 and 2020. The specific types of reforms are defined in the graphic below:

Patient-Centered Medical Home (PCMH)

- Under a PCMH model, a physician-led, multi-disciplinary care team holistically manages the patient's ongoing care, including recommended preventive services, care for chronic conditions, and access to social services and supports. Generally, providers or provider organizations that operate as a PCMH seek recognition from organizations like the National Committee for Quality Assurance (NCQA). PCMHs are often paid (by state Medicaid agencies directly or through MCO contracts) a per member per month (PMPM) fee in addition to regular FFS payments for their Medicaid patients.

ACA Health Home

- The ACA Health Homes option, created under Section 2703 of the ACA, builds on the PCMH concept. By design, Health Homes must target beneficiaries who have at least two chronic conditions (or one and risk of a second, or a serious and persistent mental health condition), and provide a person-centered system of care that facilitates access to and coordination of the full array of primary and acute physical health services, behavioral health care, and social and long-term services and supports. This includes services such as comprehensive care management, referrals to community and social support services, and the use of health information technology (HIT) to link services, among others. States receive a 90% federal match rate for qualified Health Home service expenditures for the first eight quarters under each Health Home State Plan Amendment; states can (and have) created more than one Health Home program to target different populations. For SUD Health Homes approved on or after October 1, 2018, the SUPPORT Act extends the enhanced federal match rate from eight to ten quarters.

Accountable Care Organizations (ACO)

- While there is no uniform, commonly accepted federal definition of an ACO, an ACO generally refers to a group of health care providers or, in some cases, a regional entity that contracts with providers and/or health plans, that agrees to share responsibility for the health care delivery and outcomes for a defined population. An ACO that meets quality performance standards that have been set by the payer and achieves savings relative to a benchmark can share in the savings. States use different terminology in referring to their Medicaid ACO initiatives, such as Regional Accountable Entities in Colorado and Accountable Entities in Rhode Island.

Delivery System Reform Incentive Payment Programs (DSRIP)

- DSRIP initiatives, which emerged under the Obama administration, provide states with significant federal funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. DSRIP initiatives link funding for eligible providers to process and performance metrics. Although some states may be interested in developing new DSRIP initiatives, the Trump administration has not indicated an intent to use this tool to advance delivery system reform.

Episode of Care Initiatives

- Unlike FFS reimbursement, where providers are paid separately for each service, or capitation, where a health plan receives a PMPM payment for each enrollee intended to cover the costs for all covered services, episode-of-care payment provides a set dollar amount for the care a patient receives in connection with a defined condition or health event (e.g., heart attack or knee replacement). Episode-based payments usually involve payment for multiple services and providers, creating a financial incentive for physicians, hospitals, and other providers to work together to improve patient care and manage costs.

Excerpts taken from: Gifford, K. et. al.; A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020. Kaiser Family Foundation; October 2019.

Final Thoughts…

Healthcare Expenditures as a Percentage of National Gross Domestic Product (GDP)

Gross Domestic Product (GDP) is the total monetary or market value of all the finished goods and services produced within a country's borders in a specific time period. As a broad measure of overall domestic production, it functions as a comprehensive scorecard of the country's economic health.

Though GDP is usually calculated on an annual basis, it can be calculated on a quarterly basis as well. In the United States, for example, the government releases an annualized GDP estimate for each quarter and also for an entire year. Most of the individual data sets will also be given in real terms, meaning that the data is adjusted for price changes, and is, therefore, net of inflation.

GDP includes all private and public consumption, government outlays, investments, additions to private inventories, paid-in construction costs, and the foreign balance of trade (exports are added, imports are subtracted).[1]

USA Facts[2] has compiled national healthcare expenditures as a percentage of GDP. The healthcare expenses are broken into major categories:

Year	Healthcare % of GDP	Private Health Insurance	Medicare	Medicaid	CHIP	Defense	Veterans	Out of pocket	Third Party Payers
		Totals are reflected in Millions of dollars							
1966	5.7%	10,296	1,842	1,304	n/a	1,078	1,153	18,594	6,226
1967	6.0%	10,452	4,924	3,141	n/a	1,324	1,268	18,537	5,996
1968	6.2%	11,830	6,218	3,541	n/a	1,445	1,344	20,500	6,842
1969	6.5%	13,363	7,045	4,174	n/a	1,499	1,484	22,601	7,758
1970	6.9%	15,499	7,672	5,290	n/a	1,582	1,719	24,953	8,974
1971	7.1%	17,840	8,443	6,695	n/a	1,766	1,983	26,312	9,624
1972	7.2%	20,690	9,325	8,314	n/a	1,997	2,291	28,646	10,232
1973	7.2%	22,994	10,730	9,423	n/a	2,235	2,646	31,625	11,317
1974	7.5%	26,080	13,428	11,073	n/a	2,475	2,900	34,373	12,970
1975	7.9%	30,578	16,336	13,446	n/a	2,590	3,381	37,262	14,547
1976	8.2%	37,425	19,694	15,188	n/a	2,695	4,066	40,647	16,364
1977	8.4%	45,692	22,891	17,464	n/a	2,922	4,146	44,853	18,163
1978	8.3%	52,523	26,668	19,465	n/a	3,067	4,859	48,016	20,859
1979	8.4%	60,955	30,922	22,332	n/a	3,457	5,073	52,312	24,141
1980	8.9%	69,225	37,387	26,032	n/a	3,949	5,740	58,146	28,550
1981	9.2%	81,804	44,769	30,307	n/a	4,588	6,261	65,355	32,801
1982	10.0%	94,227	52,351	32,011	n/a	5,158	6,905	72,450	36,316
1983	10.1%	105,128	59,559	35,266	n/a	5,393	7,396	78,619	38,842
1984	10.0%	119,053	66,207	38,233	n/a	5,842	8,070	86,500	41,372

[1] Chappelow, J., Gross Domestic Product (GDP); Investopedia; https://www.investopedia.com/terms/g/gdp.asp; June 2019.
[2] USAFacts is a new data-driven portrait of the American population, our government's finances, and government's impact on society. We are a non-partisan, not-for-profit civic initiative and have no political agenda or commercial motive. We provide this information as a free public service and are committed to maintaining and expanding it in the future. We rely exclusively on publicly available government data sources. Our work includes partnerships with academic institutions and experts who help keep our data accurate and unbiased. Our partners include the Penn Wharton Budget Model, the Stanford Institute for Economic Policy Research (SIEPR), and Lynchburg College. https://usafacts.org/

Year	Healthcare % of GDP	Private Health Insurance	Medicare	Medicaid	CHIP	Defense	Veterans	Out of pocket	Third Party Payers
		Totals are reflected in Millions of dollars							
1985	10.2%	131,311	71,829	40,937	n/a	6,864	8,332	95,640	46,711
1986	10.4%	136,077	76,829	45,383	n/a	7,634	8,775	103,610	53,017
1987	10.6%	149,177	83,081	50,339	n/a	8,202	9,236	109,652	59,028
1988	11.1%	175,829	88,965	55,080	n/a	8,778	9,629	120,217	66,746
1989	11.4%	204,775	101,137	61,952	n/a	9,272	10,134	126,651	70,559
1990	12.1%	233,885	110,182	73,661	n/a	10,446	10,939	137,882	77,078
1991	12.8%	255,092	120,617	93,211	n/a	11,536	11,852	140,815	82,429
1992	13.1%	274,725	135,996	108,186	n/a	11,621	12,594	143,178	88,071
1993	13.4%	295,294	149,965	122,373	n/a	12,025	13,621	144,098	93,570
1994	13.3%	308,217	167,670	134,414	n/a	11,833	14,612	142,035	97,292
1995	13.4%	325,339	184,393	144,862	n/a	12,045	14,840	144,816	100,872
1996	13.3%	343,686	198,750	152,170	n/a	11,951	15,567	150,353	104,735
1997	13.2%	359,556	210,376	160,849	n/a	12,053	15,488	161,371	110,270
1998	13.3%	384,746	209,420	169,013	399	12,201	16,333	176,811	119,946
1999	13.3%	417,089	213,173	183,471	1,723	12,654	17,509	187,575	123,037
2000	13.4%	457,985	224,829	200,383	3,012	13,709	19,082	198,886	124,920
2001	14.0%	501,945	247,686	224,132	4,167	15,424	21,083	206,200	131,403
2002	14.9%	560,971	265,381	248,100	5,485	18,856	22,782	219,274	138,865
2003	15.4%	615,143	282,668	268,963	6,296	22,224	26,517	235,636	152,243
2004	15.5%	658,200	311,122	290,743	7,167	24,898	27,951	248,495	160,901
2005	15.5%	701,058	339,762	309,351	7,566	26,496	29,802	263,816	168,987
2006	15.6%	736,676	403,690	306,680	8,366	29,765	31,861	273,611	179,506
2007	15.9%	774,731	432,751	325,850	9,117	32,262	33,198	290,381	191,754
2008	16.3%	800,156	466,971	344,423	10,210	34,031	37,686	295,573	188,435
2009	17.2%	828,493	498,859	374,734	11,106	36,670	42,463	294,167	192,142
2010	17.3%	858,481	519,783	397,410	11,540	38,301	45,723	300,223	203,350
2011	17.3%	890,466	544,781	406,727	11,988	39,973	48,170	310,434	206,450
2012	17.2%	922,048	568,477	422,904	12,624	40,003	49,758	319,236	225,493
2013	17.1%	939,125	588,928	445,204	13,497	39,586	52,840	326,864	235,877
2014	17.3%	994,119	618,549	497,767	13,212	41,449	57,931	331,766	238,795
2015	17.6%	1,060,932	648,783	542,628	14,747	41,622	64,688	341,706	244,592
2016	17.9%	1,119,914	676,772	565,380	16,777	41,190	67,449	357,217	257,340
2017	17.9%	1,175,010	705,123	580,111	18,084	41,870	72,134	365,209	270,091
2018	17.7%	1,243,050	750,182	597,387	18,583	41,722	78,025	375,610	276,939

INSIGHT is published monthly by COMCARE, a program of the County Commissioner's Association of Pennsylvania (CCAP). If you wish to provide comments or feedback, please forward your comments to Lucy Kitner or Michele Denk at COMCARE at the following email addresses: lkitner@pacounties.org; mdenk@pacounties.org. *Thank You.*