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INSIGHT

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Success of Pennsylvania's Behavioral Health Carve-Out

Survey response from Jim Leonard, LCSW, MBA; Chief Executive Officer of Magellan Behavioral Health of Pennsylvania, Inc.; November 2017

A survey was conducted by The Panto Group, LLC on behalf of COMCARE in November 2017 asking key stakeholders in the Pennsylvania Behavioral HealthChoices Program to offer their views of the program's success since its start in 1997. Jim Leonard, the CEO of Magellan Behavioral Health of Pennsylvania, Inc. provided the following response when asked, "do you believe Pennsylvania's behavioral health carve-out has been successful?"

"The decision to carve-out behavioral health managed care dollars in Pennsylvania is probably the most significant decision regarding the financing and delivery of mental health and substance use treatment services over the past 20 years. The model creates...

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Behavioral Health Integration

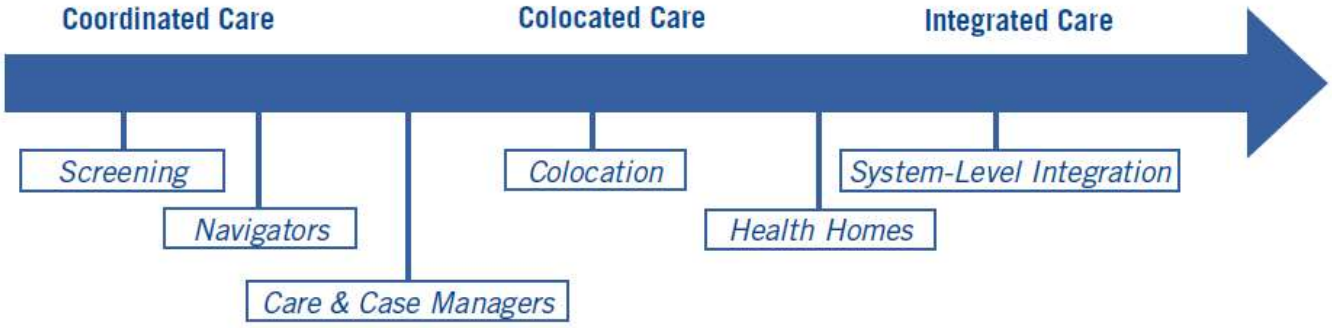
Behavioral Health Integration (BHI) encompasses a set of strategies to improve care for individuals with Serious Mental Illness (SMI) and substance use disorder through systematic coordination and collaboration among treating providers to address both

mental and physical health needs. These strategies can be arrayed on a continuum based on practice structure and level of collaboration, ranging from no integration of care to fully integrated care. The continuum can range from separate systems and practices with little communication between providers, to enhanced coordination and collaboration among providers usually involving care or case managers, to collocated care with providers sharing the same office or clinic, to fully integrated care where all providers function as a team to provide joint treatment planning and care. In a fully integrated system, patients and providers experience the operation as a single system treating the whole person.[1]

Terminology and Conceptual Frameworks

BHI is a set of strategies to improve care through the systematic coordination and collaboration of treating providers to address both mental and physical health needs. To organize the various models and strategies, a conceptual framework was created that describes a continuum of coordination and collaboration (Figure 1). The models can be arrayed across a continuum based on three practice structures (top of the arrow) and six strategies for enhancing coordination and collaboration (across the bottom). The direction of the arrow generally represents a progression from no integration (left) to fully integrated care (right); however, the six strategies may be used in combination.[2-3]

Figure 1. Continuum of Physical and Behavioral Health Care Integration*



Coordinated Care (off-site) – **Level 1: Minimal Collaboration**; patients are referred to a provider at another practice site, and providers have minimal communication. **Level 2: Basic Collaboration**; providers at separate sites periodically communicate about shared patients.

Collocated Care (on-site) – **Level 3: Basic Collaboration On-Site**; providers share the same facility but maintain separate cultures and develop separate treatment plans for patients. **Level 4: Close Collaboration On-Site**; providers share records and some system integration.

Integrated Care – **Level 5: Close Collaboration** approaching an integrated practice; providers develop and implement collaborative treatment planning for shared patients but not for other patients. **Level 6: Full Collaboration** in a merged integrated practice for all patients; providers develop and implement collaborative treatment planning for all patients.

[1] Milbank Memorial Fund; Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness; by Martha Gerrity, MD, MPH, PhD; 2014; pg 5.
[2] Ibid; pg 5-6.
[3] Figure 1 and the related descriptions of models following adapted from "A Standard Framework for Levels of Integrated HealthCare and Update Throughout the Document"; SAMHSA-HRSA – Center for Integrated Solutions; March 2013

"We hope this cost-saving analysis incentivizes payers, public and private, and drives the whole insurance marketplace to pay for peer respite [services] as an alternative to inpatient psychiatric hospitalization. Inpatient psychiatric hospitalization can be traumatic and restrictive. Respite services allow individuals to get 24/7 support during a mental health crisis."

Jamie Neckles, Chief Program Officer in the Bureau of Mental Health of the New York Department of Health and Mental Hygiene

Peer-Staffed Crisis Respite Program

A study was conducted in New York City in 2013 to help reduce emergency department (ED) visits, hospitalizations, and Medicaid expenditures for their beneficiaries. The model provided peer-staffed crisis respites, offering a voluntary, safe, and home-like environment where trained peer staff could provide 24-hour support to individuals experiencing psychiatric crises.

> "When people with serious mental illness have a crisis in their lives, often their only option for help is an emergency room or hospital"
>
> *Jonathan Brown, Ph.D, Director of Health Policy Assessment and Area Director for Behavioral Health, Mathematica Policy Research*

The study conducted by Jonathan Brown, Ph.D, from Mathematica Policy Research was to provide evidence that peer-staffed crisis respite residences reduce hospitalizations and lower the overall cost of healthcare.

Using the Parachute NYC program between January 2013 and March 2014, Parachute opened four crisis respites staffed by 20-30 peers (supervised by 3-5 non-peers), serving approximately 20 participants a month. A nurse was on-site periodically to ensure that the guests' clinical treatment needs were met.

The results showed that in the month of crisis respite use and the 11 subsequent months, Medicaid expenditures were, on the average, $2,128 lower per Medicaid enrolled month. Additionally, there were 29 fewer hospitalizations for crisis respite clients than would have been expected in the absence of the intervention, researchers stated. Researchers acknowledge that although they cannot fully explain the mechanism by which the crisis respite program achieved reductions in hospitalizations and Medicaid expenditures, certain features of the program — such as targeting patients in need of hospital care, use of intentional peer support, and the training and supervision of peer staff by experts in this model — may have contributed to its success.

Canady, V. A. (2018), Peer-staffed crisis respite program effective alternative to hospitalization. Mental Health Weekly, 28: 1-3. doi:10.1002/mhw.31553

Peer Support – happens when people with similar experiences offer each other encouragement, resources, and support. Key principles and values of peer support include mutuality, respect, shared responsibility, trust, and hope. Peer support is a natural phenomenon and occurs in many different forms. It's about understanding another's situation empathetically through the shared experience of emotional and psychological pain.

Success (continued from page 1)…

…a partnership with our county customers and allows us to continue in our shared commitment to expand access to care, to improve the quality of behavioral health services and to generate cost savings for taxpayers. We believe Pennsylvania's Behavioral Health (BH) Carve-Out has been successful, as evidenced by the following:

- *The model provides a structure to contain behavioral health costs and bend the long-term cost curve.*
- *Segregating BH Medical Assistance dollars allows state and county governments to monitor clearly that the full per-member-per-month (PMPM) rate for BH services are being allocated to the BH service delivery system. It promotes the use of taxpayer dollars to go directly to the public good.*
- *We have developed robust accountability and quality standards specifically for BH services to a vulnerable population of recipients (i. e. people with serious mental illnesses, children with serious emotional disturbances, and individuals with addictive disorders) to assure appropriate care and access to care.*
- *Counties have the opportunity to develop and customize BH services to better meet the unique needs of their to community residents. They are also better positioned to encourage the integration of BH service delivery at the county level within the broader human service delivery system.*
- *The model has strengthened the role of individual recipients of BH services and their families in influencing public policy and financing of BH services by having specific structures of input set up at both the State and County levels of government.*
- *The carve-out encourages a unified and integrated approach to leverage all the publicly funded behavioral health programs in an aligned fashion to most effectively serve individuals and their families.*
- *Through Pennsylvania's Behavioral Health Carve-Out, counties are able to reinvest cost savings gained through the efficient and effective utilization management back into the County BH service delivery system. This gives counties further incentive to manage the BH funds effectively and strengthens the BH community-based service infrastructure.*

As a follow-up, Jim was asked "what are the next steps you believe will achieve even greater success for the Behavioral HealthChoices program in the future?" His response:

- *Continued development and evolution of specialized behavioral health models to manage MH/SUD program costs and enhance health outcomes.*
- *Value Based Care models with demonstrated member outcomes that go beyond standardized HEDIS measure and support the inclusion of measurable social determinants of health, including healthcare disparities as valued outcomes.*
- *Increased focus on population health management from a BH perspective; and, the development of high performing BH provider network(s) across levels of care and/or services*
- *Value-Based Purchasing (VBP) models for BH that meet providers where they are. Many Medicaid providers still need support with care pathways and costing services and may not be ready for any type of risk-based model. New models should focus on all providers across a level of care or service –specifically, high-volume services (in both members served and dollars paid) in order to impact delivery systems. Funds (rate increases/incentive payments) should be channeled to those providers while managed care organization and other resources should be reallocated to supporting the lower-performing providers.*

Looking Toward Population Health

The article below contains excerpts from whitepaper: Leveraging ANALYTICS to Drive Population Health; produced by Leidos Health in partnership with HiMSS Media; 2018

As with many things in modern healthcare, there are new approaches and strategies to address old problems. A modern term that has entered the healthcare lexicon is called **"population health management"** – which includes collecting and analyzing data on segments of your patient populations and managing specific conditions within that population. A simplified definition is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" to improve the overall health of that population. A priority considered important to achieving the aim of population health is to reduce health inequalities or disparities among different population groups due to their social determinants of health (SDOH). SDOH includes social, environmental, cultural and physical conditions that populations are born into, grow up, and function with throughout their lifetimes which potentially have a measurable impact on that population's overall health.

As a data-driven endeavor, population health applies a broad spectrum of healthcare resources to treat specific conditions in clearly defined populations. This approach promises to fulfill the goals of the Quadruple Aim – better care for individuals, better outcomes for populations, greater staff satisfaction, and lower overall costs. Despite some success stories, success has been difficult. HiMSS Analytics asked respondents to identify the challenges they faced in population health, and three top areas stood out: technology, resources, and data. The problems ranged from failure to define and engage distinct populations, to difficulties integrating critical technology into clinical workflows and, more than anything else, to an inability to ingest data from other sources to design interventions and measure outcomes.

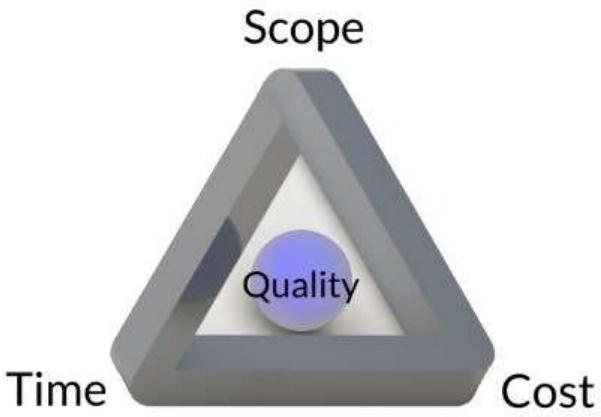
For many population health pioneers, the implementation of an EHR seemed sufficient to launch new initiatives. Nationwide, hospital estimates are as high as a trillion dollars has been spent on shiny, new EHR technology and data-capture technology… and boards are asking what they spent all the money for? Hospitals began to use EHRs as data repositories, and most are terrible at that. Then they tried to layer analytics tools over a reporting layer, and the whole process became cumbersome and slow. The EHR is able to capture some of the history and patient experience but has not been good at developing

one source of – or federated access to – a full picture of a patient. That picture now includes claims data, clinical data from the EHR, unstructured notes, an increasing variety of medical images, continuous data streams from remote patient monitoring instruments and consumer health devices, and the emerging importance of social determinants data.

But data proliferation is not tantamount to greater knowledge. For that, a provider needs a data integration and management strategy, the right analytic tools and a workforce with data-specific skills. *"Healthcare providers are realizing that true population health requires a much deeper level of analytics capability than most hospitals or healthcare systems currently have, and now they're going back to rebuild or build out their analytics capability."* (*Robert Havasy, Senior Director of Health Information Systems, HiMSS*) *"For health systems to make that investment — either in technology or in managed services — what's in it for them if they don't have a financial model that rewards them for doing it?"* (*Jonathan Scholl, President, Leidos Health*) So, several key questions remain for the future of workflow-driven population management – like: What is the population? What are we managing to? How are we going to get paid for it? Answers to these will drive the processes and workflows that will have a real impact on patient care, and overall population health.

Final Thoughts…

Why is "Project Management" important? Landscape changes in healthcare have caused counties and their managed care organizations along with service providers to re-tool how things are being done. The need for sound data analytics to meet the requirements of integrated services and value-based purchasing has sent leadership teams to the drawing board… and their crystal ball. The result is many new initiatives have begun seeking real value for those we serve, as well as for the organizations who provide the service. ***Strategic alignment with business goals*** is essential to determine who will be served, what will be delivered, how long it will take, what defines quality, what are the risks, and how much will it cost?



Project management is important because it ensures what is being delivered is right and will deliver real value in the business opportunity. ***Every project needs a leader*** who can coordinate and maximize the strengths of a team of subject-matter experts to achieve the project goal, and to control the chaos often present in anything new. Functional managers often are drafted into project management roles that they are unprepared or unable to carry… with project tasks often sandwiched in between the demands of their primary work responsibilities. Project teams struggle for coordination and direction if there is no one given the sole responsibility to be accountable to lead the project team through the tasks to achieve the goal. ***The project manager maintains the focus of the team*** on the strategic goal.

Project management also ***ensures that expectations are realistic***, and that project sponsors remain informed all along the way. To be effective, project managers must be ***diplomatic negotiators***, balancing the needs of the project with the needs of the team. No less important is ***quality control and risk management*** protecting ROI. ***Project management brings experience*** to provide continuous oversight to ensures that the right people do the right things at the right time… ***delivering success and making stakeholders happy.***

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.*