October 2018
Volume 1, Issue 7

INSIGHT

An Information Resource from COMCARE

Access to Mental Health Services Pennsylvania #1 in Survey!

What is the current state of access to mental health services in America? And, what is keeping Americans from seeking mental health treatment? Ketchum Analytics conducted a multi-phased research program using a national survey to understand the landscape of mental health access to care for the Cohen Veterans Network and the National Council for Behavioral Health. Their premise was that mental health services in the US are...

See Access to Mental Health Services on Page 4.

Inside this Issue:

Managed Care Plans on the Front Lines to Facilitate Access

Since the early 1980s, and particularly in recent years, states have increasingly used managed care to deliver services to Medicaid beneficiaries. The dominant model is comprehensive managed care, in which states contract with managed care organizations (MCOs) to provide comprehensive acute care — and in some cases long-term services and supports as well — to Medicaid beneficiaries and pay the MCO a fixed monthly premium or "capitation rate" for each enrollee. Today, 39 states...

See Front Lines to Facilitate Access on Page 2

Front Lines to Facilitate Access (continued from Page 1)

...(including the District of Columbia) contract with comprehensive managed care plans to provide care to at least some of their Medicaid beneficiaries. Nationwide, MCOs cover nearly two-thirds of all Medicaid beneficiaries, making managed care the nation's dominant delivery system for Medicaid enrollees. As the entities responsible for providing comprehensive Medicaid benefits to enrollees by contracting with providers, plans play a crucial role in shaping access to care for Medicaid enrollees.

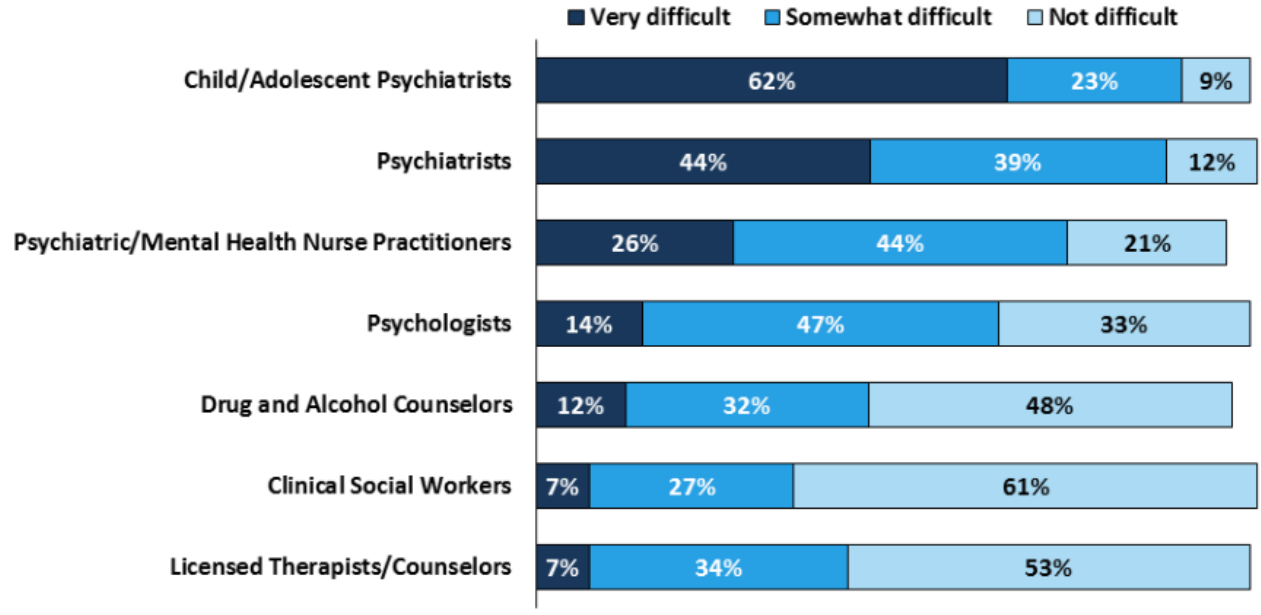
The goals of enrolling Medicaid beneficiaries in managed care plans are to promote coordinated care, help emphasize preventive care, and facilitate efforts to adopt "whole-person" delivery models that aim to address patients' physical, mental, and social needs.

Research indicates that most primary care providers and specialists accept Medicaid. However, providers are less likely to accept new Medicaid patients rather than new patients insured by other payers. In addition to provider participation, provider supply shortages in a particular state or region (especially rural areas) can affect enrollee access to care, as only 11 states currently meet at least two-thirds of their residents' need for health professionals. Plan efforts to recruit and maintain their provider networks can play a crucial role in determining enrollees' access to care through factors such as travel times, wait times, or choice of provider.

Plans also report high rates of difficulty in recruiting physician behavioral health providers to their network. These findings align with broader challenges with recruiting psychiatrists that extend across all payers, as psychiatrists accept Medicaid, private insurance and Medicare at lower rates than other specialists. (See Graph Below):

Medicaid MCO Views of Difficulty of Recruiting Behavioral Health Providers, by Provider Type

Among Medicaid MCOs contracting with each provider type, share of MCOs reporting that recruiting provider type is:



NOTES: "Don't Know" responses not shown.
SOURCE: Kaiser Family Foundation Survey of Medicaid Managed Care Plans, 2017.

THE HENRY J. KAISER FAMILY FOUNDATION

See Front Lines to Facilitate Access on Page 3

Front Lines to Facilitate Access (continued from Page 2)

The Kaiser Family Foundation conducted a survey of Medicaid managed care organizations (MCOs) from April to September 2017 to investigate how MCOs provide and monitor access to care for Medicaid enrollees. In particular, the survey aimed to capture information about MCO policies, procedures, and strategies for ensuring optimal access to care, as well as MCOs' top challenges and priorities in regard to access. When asked broadly about challenges and priorities in ensuring access to care for members, the table below outlines the highest challenges as "provider supply shortages in certain specialties and areas". The percentages shown represents the share of plans reporting by challenge and priority (see table below):

Challenges and Priorities in Ensuring Access to Care	
	Share of Plans Reporting as One of Top Three
Challenges:	
Provider supply shortages in certain specialties	65%
Provider supply shortages in certain geographic areas	62%
Capitation rate paid by the state is too low	48%
Lack of continuous eligibility for Medicaid members (i.e., "churn")	46%
Member education about how to access care	38%
Caps on providers' Medicaid patient panels	11%
Low physician participation in Medicaid	10%
Other	11%
Priorities:	
Improve integration of physical and behavioral health	49%
Implement or expand intensive care management strategies for high-risk members	43%
Improve coordination with community-based social services organizations	39%
Improve Medicaid MCO data and information systems	37%
Implement new delivery models such as PCMHs	26%
Incentivize current network providers to accept more new Medicaid patients	23%
Contract with more mental health providers	15%
Contract with more primary care providers	14%
Contract with more specialists	14%
Expand use of non-physician providers	13%
Improve member education	6%
Contract with more substance use disorder providers	5%
Other	10%

NOTES: Responses of "Don't Know" or missing are not shown.
SOURCE: Kaiser Family Foundation Survey of Medicaid Managed Care Plans, 2017.

While managed care plans are on the front lines to facilitate access to care for Medicaid enrollees, there are still many challenges to overcome. In this role, plans both work directly with their respective state governments, service providers, and enrollees to facilitate connections that break down the barriers to access to quality services. Many managed care plans are exploring alternative payment arrangements to provide financial incentives for providers to modify practices to provide high-quality, easily-accessed, and low-cost care. However, the appeal of these models varies by provider market characteristics and provider readiness to make organizational changes. In addition, there may be limits to plans' ability to create payment incentives within the capitation payments that they receive from states.

Medicaid Managed Care Plan and Access to Care; Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans; Kaiser Family Foundation; Rachel Garfield, Elizabeth Hinton, Elizabeth Cornachione, and Cornelia Hall; March 2018.

Definitions of National Healthcare Payment Reform Models

Fee for Service	•In a FFS system, payers establish the fee levels for covered services and pay participating providers directly for each service they deliver. Providers do not bear any financial risk.
Pay for Performance	•P4P is a health care payment model that rewards providers financially for achieving or exceeding specified quality benchmarks or other goals. P4P payments may be made based on performance on structure, process, and/or outcome measures, with providers evaluated against benchmarks or by comparison with other providers.
Shared Savings Arrangements	•Under shared savings arrangements, organizations or ACOs have an opportunity to share in any net savings that accrue to a payer for a defined panel of patients over a specified time period (usually 12 months). Actual costs for the patient panel are compared to a pre-established benchmark that is determined using historical utilization and/or cost data for the patient panel or a similar population. To be eligible for savings, provider organizations/ACOs must meet performance/quality requirements while also reducing costs.
Shared Risk Arrangements	•Entities that enter into shared savings arrangements with payers may also agree to share in losses. Risk-sharing is often added to shared savings arrangements after some experience has been accumulated. Under a shared risk arrangement, if actual costs for the defined patient population exceed the benchmark, the provider group/entity is accountable for a portion of the excess costs and must return funds to the payer.
Episode of Care Payment	•Episode of care payments are single, pre-established amounts paid to providers for the set of services involved in treating a patient's health event, such as a knee replacement, or a particular health condition, such as asthma, over a specified period of time. Episodes have a defined beginning and end and usually involve payment for multiple services and providers. Episode of care payments can be prospective or retrospective.
Global Payments / Bundling	•Global bundling involves a single, pre-set payment for a wide range of services delivered to an individual over a defined period of time, usually one year. Global payment amounts are risk-adjusted based on the patient's health and other characteristics that may affect the services needed, such as age or gender. In addition, global payment models incorporate outcome or quality measures to safeguard against under-service and reward high performance.

Excerpt from Medicaid Managed Care Plan and Access to Care; Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans; Definitions of Payment and Delivery System Reform Models, Kaiser Family Foundation; Rachel Garfield, Elizabeth Hinton, Elizabeth Cornachione, and Cornelia Hall; March 2018.

Eligible Counties

The counties that are eligible locations for pilot programs under the RFA were identified via a formula that equally considered the rate of individuals diagnosed with a substance use disorder (SUD) and rate of overdose-related deaths in a county. The thirty counties identified are:

Rural

- Armstrong
- Blair
- Butler
- Cambria
- Cameron
- Clearfield
- Crawford
- Fayette
- Greene
- Indiana
- Lawrence
- Mercer
- Mifflin
- Venango
- Washington

Urban

- Allegheny
- Beaver
- Berks
- Bucks
- Dauphin
- Delaware
- Erie
- Lackawanna
- Lancaster
- Lebanon
- Lehigh
- Luzerne
- Philadelphia
- Westmoreland
- York

New State Program to Help Individuals Battling Opioid Use Disorder Find and Maintain Housing in Pennsylvania

Harrisburg, PA – Governor Tom Wolf announced a new state program that aims to direct $15 million for an opioid housing initiative that will fund a minimum of eight pilot projects in eligible urban and rural communities throughout the commonwealth. The proposed pilot programs must help individuals to become and remain engaged in evidence-based treatment interventions, provide individuals with the necessary support services to maintain housing stability, and provide pre-tenancy and tenancy education services.

A Request for Applications (RFA) for support services navigation and housing services for individuals with opioid use disorder (OUD) is now available on the commonwealth's eMarketplace.

Developed by the departments of Drug and Alcohol Programs (DDAP) and Human Services (DHS), in partnership with the Pennsylvania Housing and Finance Agency and the Department of Community and Economic Development, the RFA's goal is "to support innovative practices that will increase access to treatment and supports for individuals with OUD and help prevent overdose-related deaths."

Housing instability, combined with unmet basic needs, makes the road to recovery and independence extremely challenging. According to national data, about one in five people experiencing homelessness has a chronic substance use disorder. This aligns with information gathered from Pennsylvania's 45 state-sponsored OUD Centers of Excellence, a majority of which identify housing as a major barrier for their clients.

The RFA is the first project launched as part of the $55.9 million SAMHSA grant secured to bolster the state's response to the prescription opioid and heroin epidemic. Additional initiatives included in the grant are focused on expanding services to pregnant women and veterans affected by OUD, developing the treatment and recovery workforce, and strengthening criminal justice and law enforcement initiatives with a focus on reentrant supports.

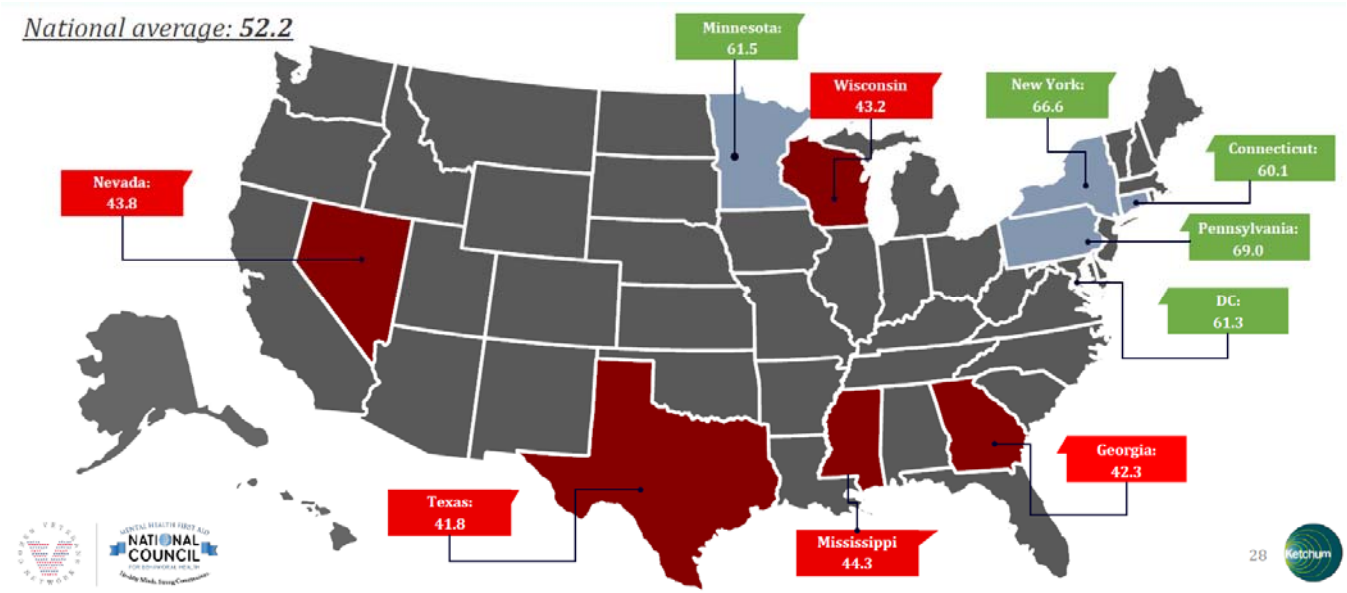
The Substance Abuse and Mental Health Services Administration (SAMHSA) has distinguished four major dimensions that support a life in recovery: health, home, purpose, and community. This project aims to support two components of the dimensions – home and purpose. By giving an individual a stable, safe place to focus on their recovery, paired with the independence and self-worth that housing provides, an individual's overall health and wellbeing is greatly improved. (See eligible counties in box to the left).

Press Release; New State Program to Help Individuals Battling Opioid Use Disorder Find and Maintain Housing in Pennsylvania; www.governor.pa.gov; October 17, 2018.

Access to Mental Health Services (continued from page 1)

...insufficient despite high demand, with the root cause being the inability to get an appointment. Based on the survey results, the estimated demand for mental health services are 141 million (56% of American adults have sought or wanted to seek treatment for themselves or others). Here is a striking survey result: Almost half (46%) of those who have never sought treatment would not know where to go if they needed to seek mental health services for themselves or a family member or friend. Lower perceived levels of access are felt more among rural and low-income Americans.

The ability to get mental health services is the number one challenge to mental health care. Issues with getting seen go beyond basic availability of services – proximity, cost, and wait times are all part of the problem. It is estimated that 96 million American adults (38%) have had to wait longer than one week for mental health services. And nearly half (46%) of American adults have had to travel more than 1 hour roundtrip to get to their most recent mental health care appointment. Despite these travel times, very few Americans use telehealth services, which just 4% of those who have sought mental health treatment for themselves have tried. Barriers to seeking mental health treatment includes cost / poor insurance coverage, not knowing where to start, the social stigma around seeking treatment, and quality of care. America's Mental Health 2018, commissioned by the Cohen Veterans Network and the National Council for Behavioral Health provides current and comprehensive coverage of mental health service access in each state. The mental health index measures patients' access to services in terms of four pillars – providers, facilities, funding, and perceived satisfaction among patients – aggregated and averaged to rank each state. Pennsylvania ranked 1st for overall index score (69.0) in the survey with the highest overall satisfaction rating of 91.2 (See the graphic below showing the top 5 states [green], and bottom 5 states [red]).



Access solutions will come through improved visibility of mental health issues and education of patients. A strong network of support comprised of service providers, insurers, patients and their families working together is critical to providing patients with the treatment they need.

Excerpts taken from "America's Mental Health 2018"; presentation by Cohen Veterans Network and the National Council for Behavioral Health; October 10, 2018.

How "Wrong Pockets" Hurt Health

Every month about 30 researchers, policy makers, and practitioners from 4 different sectors—health, education, housing, and social services—meet at the Brookings Institution in Washington, DC. We discuss policy reforms that would boost collaboration between sectors to improve the health of households and communities. We are especially interested in "social determinants"—nonmedical social factors affecting health.

The focus of a discussion might be children's mental health, housing conditions, or aging. But whatever the topic, it is never long before someone raises an example of a "wrong pocket problem" undercutting the incentives for collaboration. A wrong pocket problem arises when one organization or sector is best placed to make an investment, but it is another sector—another pocket—that benefits from the investment. As any economist would point out, when a potential investor incurs the cost but cannot capture the generated value, there will be underinvestment.

A WRONG POCKET PROBLEM ARISES WHEN ONE ORGANIZATION OR SECTOR IS BEST PLACED TO MAKE AN INVESTMENT, BUT IT IS ANOTHER SECTOR—ANOTHER POCKET—THAT BENEFITS FROM THE INVESTMENT. AS ANY ECONOMIST WOULD POINT OUT, WHEN A POTENTIAL INVESTOR INCURS THE COST BUT CANNOT CAPTURE THE GENERATED VALUE, THERE WILL BE UNDERINVESTMENT.

Wrong Pockets vs Social Determinants

This issue is important in health care because the research literature increasingly emphasizes the importance of nonmedical factors in health. For instance, the absence of quality medical care appears to account for perhaps 20% of avoidable deaths and genetics another 20%. But social, behavioral, and environmental factors may account for as much as 60%.

The wrong pocket problem reduces optimal investment in nonmedical factors that would improve health outcomes. Examples abound. For instance, according to the Centers for Disease Control and Prevention, more than 800 000 people—disproportionately elderly—are hospitalized annually because of falls, costing the health system about $50 billion. Many of these falls result from uneven steps, loose rugs, bathrooms lacking features optimal for elderly individuals, and other home hazards. Spending money on home safety could sharply reduce medical costs and improve lives. But the housing agencies or private landlords who would foot the bill would see none of those savings as a return on their investment, so there is little financial incentive to make changes for health reasons.

Other examples include patients who miss appointments or fail to pick up prescriptions for want of adequate bus transportation, and children whose mental health deteriorates for lack of family counseling. In each case, investment in a nonmedical service sector would produce health savings or improvements, but the wrong pocket problem gets in the way.

Four Necessary Steps

What should be done to address this pervasive problem? Action is needed on several fronts.

- *One critical step is to expand and refine the research demonstrating the relationship between social investments and improved health outcomes.* It is hard to make the case for health-related spending in a nonmedical sector without studies showing the potential return on investment.
- *A second needed action is to break down silos between government agency budgets*, so the prospect of crossover benefits becomes more influential in government budgeting.
- *A promising third strategy is, in effect, to bring all the pockets into the same budget process by creating bodies dedicated to enhancing health rather than only providing medical services.* In

this way, the full cross-sector value of investments is incorporated into the business model, by bringing in-house the investment and spending decisions for their enrollees that currently are made in other sectors. With such a business model in place, it is possible that the hospital or clinic of the future could evolve into a "mall" for a wide range of health-related services, such as housing, social services, and parenting education. Medicaid managed care organizations (MCOs), Medicare Advantage plans, and similar health plans are well positioned for such a model because they receive capitated payments to keep enrollees healthy and have the financial incentive to do that creatively and well. They have a strong motivation to address social determinants that will pay off in reduced medical costs. And many already do. But much more flexibility is still needed if managed care is to be able to focus on the determinants of good health, not just on medical care.

- *A fourth step is to test new organizational models that would mitigate the wrong pocket problem by creating procedures for the costs and benefits of cross-sector collaboration to be identified and built into decision making.* Auditing firm KPMG is helping health organizations do this. Meanwhile, other intriguing ideas include approaching the problem as a classic example of the need to find ways to fund public goods and to address "free riders" who reap benefits without investing in activities that actually generate those benefits. Drawing on an economic model designed to address these issues, they propose an organized bidding process within communities in which stakeholders would have to offer to share the investment cost. This process would be managed by the type of trusted intermediary that is already a common feature of successful collaborations.

The increasing attention to the nonmedical social factors in health is important for constructing a future system that enhances health, rather than one focused only on fixing medical problems. But for our system to evolve in this way, we need to address perverse incentives and deficiencies in health care's business model. The wrong pocket problem is one of the most troublesome of these.

Excerpts from: How "Wrong Pockets" Hurt Health; The JAMA Forum; Stuart M. Butler, PhD; August 22, 2018

Final Thoughts…

Current healthcare challenges have prompted government leaders, managed care strategists, and service providers to become more strategic as they make plans for the future. These key stakeholders have utilized Organizational Project Management (OPM) experts to understand their own respective organization's vision and mission – defining strategy, products and services, desired profits and performance to maintain compliance and achieve a competitive advantage in the healthcare market. They are matching the right people with the necessary skills to modify their organizational structure, and evaluating their own internal business processes (automation, metrics, communication, and simplification of complexities). ***Internal assessments are essential to define the necessary changes.*** Assessment experts plan, execute, and manage the assessment process; compile and analyze the data and documents, and provide stakeholder leadership with results and recommendations strategic change.

- See more at: https://www.pmi.org/learning/library/grow-up-already-opm3-primer-8108

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.*