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COMCARE
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INSIGHT

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Lawmakers Consider Sweeping Changes to Behavioral HealthChoices Program as New Session Begins

Legislation to End the Behavioral Health Managed Care Approach and Challenges to the "Carve-Out" Anticipated

As lawmakers and the Wolf administration prepare for another difficult budget year, the COMCARE team, county commissioners, providers and advocates across the state are mounting a statewide advocacy campaign to protect county oversight and management of the Behavioral HealthChoices program.

Continued on Page 2

Inside this Issue:

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Continued from Page 1

The goal of this initiative is to ensure the continued delivery of high-quality care for almost 3 million Pennsylvanians and their families who rely upon Behavioral HealthChoices for life-saving services.

In 2018, the Senate considered a bill that would have required the Medicaid program to contract with any drug and alcohol provider. This "any willing provider" provision would have ended local oversight and, ultimately, shredded the managed care approach that is a pillar of Behavioral HealthChoices. Thanks to the support and hard work by many of our stakeholders, this legislation did not advance to Governor Wolf's desk in 2018 but is likely to be re-introduced this year.

In addition, the COMCARE team has met with lawmakers and legislative staff who anticipate introducing legislation, which has yet to be drafted, designed to create savings in the program. These proposals are relatively vague at this point. However, there is increased discussion regarding a fundamental change to the very heart of this successful program: ending the carveout of behavioral health services altogether.

The carve out was instituted 20 years ago in the Ridge administration and has been so successful over the years that it has strong support from Governors Rendell, Corbett, Wolf and the legislature. Behavioral HealthChoices was created because the 'carved in' model was failing Pennsylvanians and their families and was too costly.

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Under county-led management, and with strong support from member advocate organizations and the provider community, the Behavioral HealthChoices program has evolved to become an effective and efficient model for delivery of these services to a challenging population. In fact, other states have looked to Pennsylvania's model as they developed their own programs to care for this vulnerable population. Today, more Pennsylvanians are accessing a wider array of services than ever before. Any fundamental change to this model jeopardizes that care.

The program has also served as an incubator for specific initiatives designed to spur stronger integration of physical and behavioral health services for members while ensuring that vital behavioral services are not weakened. Specifically, the clinical integration of behavioral and physical health has included comprehensive physical and behavioral health screenings, member engagement, shared development of care plans and care coordination and navigator support, among other elements of improved care.

This effort included the launch of two successful pilot projects in Allegheny County and in southeast PA. (For more information on these two initiatives and the positive results they delivered, please review the COMCARE Behavioral HealthChoices White Paper available at http://www.ccapcomcare.org/Pages/AboutUs.aspx

As we look ahead, we are urging all stakeholders to take just a few minutes and share this article with your colleagues, partners, and other important stakeholders.

The COMCARE team will provide additional resources in the coming weeks that will make it easier for all of us to contact our state lawmakers and urge them to ensure the continued success of the Behavioral HealthChoices program.

In the interim, please send any questions or feedback to Lucy Kitner or Michele Denk at COMCARE at the following email addresses: lkitner@pacounties.org; mdenk@pacounties.org.

Whole Person Integrated Care and Community Wellness

Whole Person means your health and wellness are not limited to your behavioral and physical health but on the well-being of you as the whole person. We know that social determinants of health such as emotional, financial, social, spiritual, occupational, and physical health contribute to our client's wellness. Modern healthcare places the individual at the center, playing a partnership role with their healthcare providers to decide the best way to maintain their health and well-being. Healthcare should be made convenient and easy to navigate so that it fits within the individual's day to day life. The easier the healthcare system is for the individual, the more likely they remain healthy and resilient.

Unfortunately, there are barriers that have impeded on the national healthcare system that affect positive behavioral and medical health outcomes. Here are some of the most challenging barriers[1]:

- *Access to care, and the challenges of rural healthcare capacity.*
- *Over-using high-cost emergency department visits, especially for persons with serious behavioral health issues and complex medical conditions, or crisis contacts that are inappropriate to the service need.*
- *A focus on a limited definition of health that excludes either physical or behavioral health; without a holistic focus on wellness.*
- *A fragmented service system operating in siloes without a common agenda or voice.*
- *Difficult or non-existent data sharing capacity to manage and track outcomes across providers or to aggregate or evaluate performance.*
- *Poor integration of behavioral health and the primary care of medical conditions frequently resulting in co-location only, limited referral options, and rarely true integration. When they are combined, social, organizational and community health and wellness are often excluded. The resulting focus on crisis results in a reactive versus proactive system.*
- *Failure to incorporate social determinants of health (SDOH) as part of a comprehensive model, considering that sixty percent of health impact results from behavioral, environmental and social conditions.*
- *Disproportionate focus on intervention with limited attention to prevention and promotion, in essence supporting the ballooning of health costs by not attempting to limit and reduce the number of individuals in need of intervention and potentially high cost services.*
- *Individuals are often provided prescriptions and interventions with limited health education and implementation support. Lack of follow-through on provider recommendations is a key contributor to negative health outcomes.*
- *A lack of defined outcomes to evaluate clinical and program impact can result in wasted resources or insufficient emphasis on critical and successful outcomes.*

Pennsylvania faces many of the same challenges outlined in the national healthcare barriers above. However, over the past two decades Pennsylvania counties have been successfully finding solutions to treat the state's most needy, leveraging the benefits of the Behavioral HealthChoices Program.

County human services departments have known best how to effectively use their resources to meet the special needs of their clients through services incorporating social determinants of health. New and innovative programs built upon the cost savings of the Behavioral HealthChoices Program have enabled Counties to successfully build a behavioral healthcare model that overcomes barriers and promotes "whole-person" health

[1] Kaufman, Martha et. al., Whole Person Integrated Care Model: Advancing the Quadruple Aim and Community Wellness; Partners Behavioral Health Management; 2017

Delivery System Reform

Reform involves altering care delivery, payment incentives, or both to stimulate and sustain delivery system changes. The Commonwealth Fund (CF) has written a whitepaper that evaluates options for integrating service delivery system reform loosely into three general categories:

- accountable care organizations (population-based care management)
- medical homes (individual-level care coordination), and
- bundled payments (episode-specific coordination)

CF found in their analysis of the issues that the evidence base for these payment and care delivery models demonstrates promising trends but is still growing as models continue to be developed and evaluated. Given the lack of any "gold standard" health care delivery models as well as the variation in populations, markets, and geographies across the country, delivery system reform continues to be an evolving process of innovation and evaluation.

In designing policies that incorporate new payment and care delivery models, CF has identified three main principles that are critical for success:

- information sharing and infrastructure
- flexibility to innovate, and
- alignment and stability of efforts.

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Information Sharing and Infrastructure

Electronic health record (EHR) interoperability and the development of patient-owned medical records are crucial for providers to better manage their patient populations across different sites of care, including primary care and specialty clinics. Coupled with improved interoperability, the development of health information exchanges can provide more macrolevel data for population management, such as tracking readmissions to hospitals in different health systems. Data can catalyze improvement, including provider-specific and patient-level information on the processes, cost, and outcomes of care. Additionally, bringing such information and data to the point of care can better engage patients in clinical decision-making, addressing a challenge in current delivery models.

Flexibility to Innovate

Various provider types, patient populations, and local markets respond to different incentives. Moreover, providers and patients across the country have different expectations of how they interact with each other and navigate the health care system — interactions that are affected by the history of the region, market fundamentals such as provider and plan concentration, geographic characteristics, and patient socioeconomic characteristics. Enabling flexibility to adjust models to the needs of particular environments can contribute to success. State Innovation Models Initiative grants have provided states with the opportunity to implement multi-payer health care delivery reforms across Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). Maintaining a balance of tailored and nationwide approaches will further enable policymakers to meet the diverse needs across the country.

Alignment and Stability of Efforts

Lack of alignment on the expectations, incentives, and measures of accountability across private and public payers, purchasers, and providers could dilute the focus of reform efforts and severely hamper systemwide change. If providers are held accountable to completely different quality metrics and payment structures depending on what type of insurance a patient has, they are less likely to consistently change their behaviors and how they provide care. Alignment of program characteristics — such as how a patient gets "assigned" to a particular provider, what quality metrics are used for performance evaluation, and how financial rewards or penalties are calculated and allocated — will play an important role in ensuring delivery system reform efforts are as effective as possible. Alignment could occur at different levels, such as state or federal, or across payers or providers. Although alignment is important to optimize investment in these models and reduce burden on providers, it should be balanced with the need for flexibility as discussed above. Sharing lessons from successful delivery system reform efforts with those designing and participating in such initiatives will allow for stability and improvement over time.

Conclusion

Ongoing and future delivery system reform efforts should continue to build the evidence base of what works and what does not in the move toward improved health and smarter spending in our health care system. Policymakers and health care leaders also should recognize and strive to overcome limitations of alternate payment models and other value-based payment models to date.

Excerpts from: Moving Toward High-Value Health Care: Integrating Delivery System Reform into 2020 Policy Proposals; Issue Brief from The Commonwealth Fund; Seshamani, M. et. al.; November 2018.

Final Thoughts…

Macroeconomic forces are changing the rules of the business game for both payers and providers. Under the old rules, providers could do what they thought best with little regard for cost, while payers paid claims with little regard for what medical interventions worked. And both sides could win. Under the new rules, payers and providers win only when they work together to produce the best possible clinical outcomes at the lowest possible costs.

In fact, a recent survey of nearly 500 payers and providers commissioned by McKesson found that more than two-thirds of the respondents expect value-based payment models to be the norm between payers and providers by the year 2020.

The most important skills to possess in the new game, or core competencies for payers and providers, are the willingness and ability to share information and ultimately put actionable clinical and financial data in the hands of caregivers and utilization managers at the point of service.

Excerpts from: Three Steps Leading to Successful Payer-Provider Collaboration; By Holly Toomey, RN, BS, HCA, McKesson; Holly Toomey, RN, BS, HCA is director, product management at McKesson Health Solutions.

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.*