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INSIGHT

An Information Resource from COMCARE

In Support of the HealthChoices Behavioral Health Carve-Out

The Integration of physical and behavioral health to treat the whole person are being developed in every state throughout the nation. Some stakeholder voices approach the issue with the belief that behavioral health should be integrated into the physical health system. Others believe the opposite to be true, pursuing healthcare parity for behavioral health and integrating physical health into the community behavioral health setting. And then there are many combinations of these two viewpoints being debated in state legislatures, amongst national commercial insurance companies, provider stakeholder associations and county human service departments. The only constants…

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Protect Behavioral HealthChoices

COMCARE's advocacy campaign to protect county oversight and management of the Behavioral HealthChoices program. See information update on page 2.

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uniting the many interests represented is the concept of treatment of the whole person, and the pursuit of the quadruple aim.[1]

There is no single simple solution to bring together all the essential pieces of holistic healthcare. Much of what is being done is metered steps forward to overcome barriers and organically grow and evolve the national healthcare system into a more integrated and better whole. Local networks of service providers are working with their respective payers, governmental bodies (counties, states), hospital systems and physicians to overcome the challenges of the current system. They seek to weave together a more effective integration of care for the improved health of their clients / patients, and to manage costs – particularly in Medicaid managed care, the Nation's largest healthcare insurer.

The Behavioral HealthChoices Program in Pennsylvania is the behavioral health managed care "carve-out" that serves the specialized needs of the mental health and substance use disorder populations. Two of the most compelling successes[2] of the Behavioral HealthChoices program are:

- the unique partnership that has been forged between the state, counties, and their respective behavioral managed care organizations and community provider networks, serving over 2.9 million Pennsylvanians; and, (*continued on page 3*)

[1] Quadruple Aim, developed by the Institute for Healthcare Improvement (IHI) in 2007, consisting of: 1) Improved health outcomes; population health; 2) Lower costs; eliminate waste; 3) Better patient experience; improve patient satisfaction; and, 4) Improved physician, community provider and care team satisfaction; team well-being; better work experience.

[2] See summary of the Behavioral HealthChoices Carve-Out in the County Commissioner's Association of Pennsylvania Community Managed Care Resource (COMCARE) Whitepaper: "HealthChoices Behavioral Health Managed Care, 20th Year Anniversary (1997-2017); The Model of Successful Behavioral Healthcare in Pennsylvania. Find on COMCARE's website: http://www.ccapcomcare.org/Pages/AboutUs.aspx

PROTECT BEHAVIORAL HEALTHCHOICES

Behavioral HealthChoices is under fire in Harrisburg: at least one physical MCO is pushing to 'carve-in' the program. They contend the state can realize significant savings and improve care by merging the programs.

There is an ongoing discussion about the need to bolster integrated care. Behavioral HealthChoices provides a mature framework with a very specialized population to provide integrated "whole-person" care.

COMCARE has enlisted the assistance of Charlie Curie, prior Deputy Secretary for Mental Health and President of the Curie Group, LLC, Brad Shopp, from Feinberg Shopp Associates, and Pete Shelly, from Shelly Lyons to inform and educate state legislators of the value of the current Behavioral HealthChoices model.

You can help by:

- Creating round-table discussion with members who can highlight the value of the program
- Send letters to your County Commissioners and Lawmakers to explain why Behavioral HealthChoices needs to be protected
- Provide testimonials that can be used to share with Lawmakers.

You can call Pete Shelly's office at 717.724.1681 – Pete and his team can talk with you about the campaign.

- the overwhelming cost savings the State – estimated from $11 to $14 billion statewide through from implementation in 1997 to 2016.

It would be hard to calculate the overall cost savings and increased service capabilities to the local county human services departments in all of Pennsylvania's 67 Counties due to the Behavioral HealthChoices program. County human services systems have leveraged the financial resources, program development, quality improvements, program integrity, and overall systems integration to provide a full continuum of healthcare services tailored to their local needs. Counties have known best how to braid together the array of Medicaid, non-Medicaid, and local funded programs within their human services and criminal justice departments. Local county oversight enables the coordination of the social determinants of health so valuable to holistic healthcare for their constituents.

The Pennsylvania House of Representatives is in the process of introducing legislation in 2019 that would structurally change the Behavioral HealthChoices program from a specialized "carve-out" (as it is currently), to a model that "carves-in" behavioral health services into the current physical health managed care plans. While this proposed change is intentioned to provide the best outcomes and best care for people with complex health needs, it would take down the current successful and stable Behavioral HealthChoices program. The proposal to carve-in presumes administrative cost savings and improvement on whole-person care.

The Behavioral HealthChoices program has already shown estimated cost savings to their respective specialty population of up to $14 billion over 20 years, while reinvesting over $834 million to develop capacity and access to services. This was achieved by strong

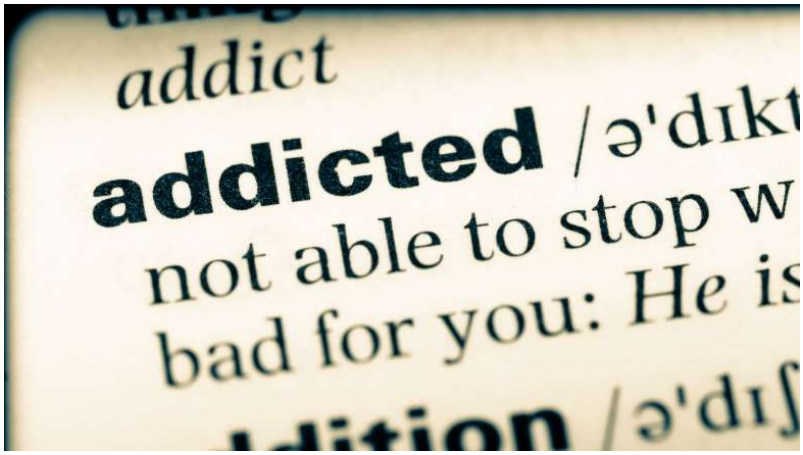
COMCARE believes that the current Behavioral HealthChoices carve-out should be preserved. Service delivery innovations in integrated holistic treatment are being made in every county, working with their respective behavioral and physical health managed care organizations.

administrative controls designed to assure that Medicaid funds go directly to service provision – medical averages over 90% of capitation revenue. In addition, no more than 3% of capitated funds can be reserved for reinvestment, with any excess being returned to the state. These are strong controls to assure that capitation savings do not go towards unaccounted profits of the managed care companies.

Behavioral HealthChoices has long been involved in the development of innovative ways to promote and deliver whole-person care, most recently with developing Certified Community Behavioral Health Clinics.[3] The Behavioral HealthChoices program in connection with all of the local county-based resources are not only moving to a broader delivery integrated care but are incorporating the related social determinants of health that are integral to holistic healthcare.

There is significant concern that even if the state would pursue carving behavioral health services back into existing physical health plans, that the physical managed care companies may still need to contract with specialized behavioral health managed care organizations that possess the expertise in these specialty populations. The financial implications would only work to cause additional tiers of administrative overhead to the system and create additional degrees of separation from the local county oversight and benefit. Moreover, the burden that would be shifted back to local county human services departments would be extreme, with potential cost savings going to physical health plans rather than toward behavioral health recipients.

COMCARE believes that the current Behavioral HealthChoices carve-out should be preserved. Service delivery innovations in integrated holistic treatment are being made in every county, working with their respective behavioral and physical health managed care organizations. Improvements involving care coordination, technology, and value-based purchasing are being done to build upon the systems and successes of the current carve-out program. We support the continued improvement and evolution of the existing carve-out model that best meets the needs of our citizens and invite continued collaboration with our state policy makers.



Addicted? Seek Help. You Don't Need to Be Alone | Opinion

Addiction is a lonely, lonely disease. Addicts struggling with alcohol, heroin, or prescription drugs or any other substance will often isolate themselves from their family, their friends and any type of support system that might be available to them because the disease takes over and drives their every decision. It's a scary place to be: completely alone and hopeless.

Breaking through this sense of isolation is one of the first barriers that I face when I respond to a call from one of our local hospitals to help an addict who has survived an overdose. I work for the Rase Project in downtown Lancaster as a Recovery Specialist under the Warm Hand-Off for Overdose Survivors Program. Hospitals will call me at any hour of the day or night to literally hand the overdose survivor off to me and I am responsible for helping these men and women gain access to whatever assistance they need. (*continued on page 5*)

[3] See INSight, November 2018 article: SAMHSA Provides 2017 CCBHC Statistics to Congress; and the referenced SAMHSA Report on the COMCARE site: http://www.ccapcomcare.org/Pages/Information.aspx).

For overdose survivors, that means admission to a rehabilitation facility as the first step toward recovery. I can talk with my new client and help identify the facility that makes the most sense for them.

I also work as a monitor in a recovery house, where dozens of people in recovery come for a wide array of support services which include everything from help drafting a resume to an Alcoholics Anonymous meeting or other 12-step program. Our door is always open to anyone in recovery who needs a safe place to catch their breath.

I see first-hand the devastation that the opioid crisis is causing in our community. This disease doesn't discriminate; young, old, men, women, black, white, Asian, Hispanic, rich, poor, everyone is vulnerable. It never lets up: my colleagues and I, along with dozens of other service providers in our county are dealing with an ever-growing demand for services.

But people can find help. I know because I did. Like each of my colleagues at the Rase Project, I am in long-term recovery. I am one of the survivors, so I know the challenges that addicts face when trying to find help.

The good news is that our community has developed a strong and growing network of support services to help our citizens battle addiction. Lancaster County is part of a five-county umbrella group called the Capital Area Behavioral Health Collaborative, which administers a state program called Behavioral HealthChoices.

Because of this program, Lancaster, along with Dauphin, Perry, Cumberland and Lebanon counties can develop specific services, including

The Rase Project is a non-profit that serves the recovery community throughout central Pennsylvania. The community is defined as any person in, or seeking recovery, their families, close friends and other loved ones. For more information, please visit www.raseproject.org.

those for drug and alcohol addiction challenges, that meet each county's needs. The Behavioral HealthChoices Program, and the continued coordinated support of the County Human Services Departments, is a driving force behind our community-wide response to the opioid epidemic.

All professionals working in our field recognize the great partnerships that have been developed among the county, city officials, area hospitals, first responders, and a wide array of non-profits. We recently hosted a Resource Recovery Fair at our center and more than two dozen groups and organizations were on hand providing information about services that recovering addicts and their families might need.

I feel extremely fortunate to be one of the survivors and I am proud of the fact that I have gone through the training necessary to be a Certified Recovery Specialist. My own path has led me full circle from first needing these services to now helping provide them.

My message to anyone reading this is that help is available - and it is available right here throughout central Pennsylvania. Please, ask for it. Ask a friend, a family member or your doctor. Jump online and look for your county's online guide for those seeking help.

You do not have to be alone.

Excerpts from: Hildebrandt, Brandon; Addicted? Seek help. You Don't Need to be Alone | Opinion; PENNLIVE.COM; https://www.pennlive.com/opinion/2018/07/addicted_seek_help_you_dont_ne.html ; July 3, 2018

Center for Medicare and Medicaid Innovation Will Get More Involved in Social Needs Driving Health Issues

Alex Azar, Secretary of Health and Human Services

In recent years, the government has turned its attention to addressing social determinants of health as a way to reduce costs and keep patients healthy. Secretary Azar outlined how his agency is planning to get more involved with addressing social needs that impact patients' health. He noted that by its very name, his agency covers not just health, but also human services, which means HHS is set up to think about all the needs of vulnerable Americans. And while the federal government will continue to take the lead on financing healthcare, "we believe we could spend less money on healthcare—and, more important, help Americans live healthier lives—if we did a better job of aligning federal health investments with our investments in nonhealthcare needs."

The administration is considering how to improve healthcare and social services with a decentralized, flexible approach. For instance, common needs across the country may be nutrition and housing, but in rural areas transportation may be the real challenge, he said. "Just like how every patient is different in healthcare, every person has unique social service needs—and we are intent on designing models that connect them to the services they need, rather than offering a one-size-fits-all approach," Azar said.

Integrated and coordinated systems of care are needed to provide care for patients with overlapping medical, behavioral health, and social needs, many of whom are served by the Medicaid program, but that funding is often an issue. "Having the Medicaid program really value social determinants of health, and really value the idea that health is not just about healthcare—it's about the conditions in which we live and work—I think it's a critical step forward for the administration and a critical step forward for the field, as well." (*Mavis Asiedu-Frimpong, Director for National Initiatives at the Camden Coalition of Healthcare Providers*).

Payment models lie at the center of innovative change considerations by the Centers for Medicare and Medicaid Services. In November 2018 HHS Secretary Alex Azar announced that CMS was interested in paying for housing and other social services.

"In our very name and structure, we are set up to think about all the needs of vulnerable Americans, not just their healthcare needs.... What if we went beyond connections and referrals? What if we provide solutions for the whole person, including addressing housing, nutrition and other social needs? What if we gave organizations more flexibility so they could pay a beneficiary's rent if they were in unstable housing or make sure that a diabetic had access to, and could afford, nutritious food? If that sounds like an exciting idea ... I want you to stay tuned to what the Center from Medicare and Medicaid Innovation (CMMI) is up to."

- Alex Azar, Secretary, Health and Human Services

Excerpts from: Joszt, Laura, Azar: CMMI Will Get More Involved in Addressing Social Needs Driving Health Issues; American Journal of Managed Care; November 16, 2018.

City of Philadelphia: Combining Housing And Health Care Resources To Reduce Chronic Homelessness

A "recovery-oriented system of care" is central to the City of Philadelphia's effort to end chronic homelessness. This approach involves providing the clinical care that... (*continued on page 8*)

…individuals need to address their mental health or substance use challenges, and also ensuring that they have the social and other supports they need to participate in school or work and be part of their communities. Integrating physical and behavioral health care is also key to the model. The success of Philadelphia's approach depends, in significant measure, on the availability of Medicaid-covered services and payment.

Medicaid's role

A key feature of the relationship between Pennsylvania's Medicaid agency and the counties in the state has been instrumental to Philadelphia's progress in reducing homelessness. Specifically, while the Medicaid agency contracts with managed care plans to provide physical health services for Medicaid beneficiaries, the state gives counties the opportunity to manage behavioral health services for its residents. The City of Philadelphia, which is also a county, established a single-payer system for public behavioral health care in its jurisdiction. The City's Department of Behavioral Health and Intellectual DisAbility Services (DBHIDS) receives capitation payments totaling about $800 million from the Medicaid agency and is at full financial risk for the administration of the Medicaid behavioral health benefit for approximately 600,000 Medicaid enrollees.

The vast majority of people served by DBHIDS – roughly 85 percent – are Medicaid-eligible. The City of Philadelphia also receives state and federal block grant funds to cover people who are not eligible for Medicaid and services that are not covered by Medicaid. The City is able to tailor behavioral health services to meet individual needs and manages these multiple funding streams behind the scenes. Through implementation of evidence-based practices, early intervention, and an emphasis on long-term recovery, DBHIDS has been able to achieve Medicaid savings and reinvest them in system improvements, including an initiative to house individuals experiencing homelessness, as described below.

Pathways to reducing homelessness

A core component of Philadelphia's strategy to end homelessness is its Permanent Supportive Housing (PSH) initiative, which involves DBHIDS and the City's Office of Homeless Services.

DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Importantly, most individuals housed under the PSH initiative are eligible for Medicaid coverage, which provides a source of payment for the health services they receive. There are three different pathways to housing:

- **Housing First** serves more than 500 individuals facing chronic homelessness and severe psychiatric and/or substance use disorders. The premise of the Housing First model is that people need to be stably housed to benefit optimally from other services and supports; thus, participants do not have to comply with conditions like agreeing to psychiatric treatment before they move in. Once individuals are housed, the City provides them with clinical care, targeted case management, mobile psychiatric services, peer-to-peer services, and other services. Medicaid pays for these services for residents who are Medicaid beneficiaries.
- **Journey of Hope** is a residential substance use disorder treatment program for people with a history of chronic homelessness and long-term serious addiction. It was launched in 2007 after the City's Homeless Death Review found that drug intoxication/alcoholism was the leading cause of death among people experiencing homelessness. By 2014, Journey of Hope had helped 443 persons achieve a variety of desirable outcomes, such as reuniting with family, obtaining

treatment for other health or mental health problems, and moving into PSH.

- **Safe Haven** is a City program that brings people indoors during inclement weather and uses the opportunity to engage them in treating their substance use problems and move them to PSH quickly. Nearly 220 people have moved into PSH through this program.

Results

Data on Philadelphia's PSH initiative show that, of the roughly 1,200 chronically homeless participants brought into PSH over the last eight years, 89 percent remain in stable housing and are not using crisis services. DBHIDS' costs rose initially when the programs got underway because the use of behavioral health services increased among the individuals served. However, costs dropped substantially after people were housed. For example, the City's behavioral health costs were $85 per day per person for individuals in the Safe Haven program two years prior to their entry into the program. These costs rose to $112 during the engagement period, then fell to $18 once the person was housed. Similar cost-saving patterns were seen in the other two programs.

DBHIDS officials identified lessons from their experience that may be relevant to planning for other Medicaid-housing partnerships. Most importantly, a clinical framework based on pursuing long-term recovery is key for persons with addiction disorders. Dr. Arthur Evans, DBHIDS Commissioner, observed that addressing housing and other social determinants of health has helped to achieve annual savings averaging about $15 million in the behavioral health care system. "If you factor in physical health outcomes, such as improvements in the management of chronic conditions like diabetes, hypertension, asthma and others," he said, "the savings can be even more robust." In addition, health care financing strategies are essential to operate the range of services needed; intentionally capturing Medicaid payment for services provided to eligible individuals in PSH is both appropriate and feasible and can enable resources available for housing to go further.

Excerpts from: Paradise, Julia et. al., Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples; Kaiser Family Foundation Issue Brief; January 2017..

Final Thoughts…

Forging Medicaid-housing linkages will require new dialogues between agencies and programs with different administrative structures, financing systems, cultures, and operations, and with little previous interaction at the federal, state, or local level. Integrating Medicaid and supportive housing appears to have particular potential to improve health and housing outcomes and reduce avoidable costs for people with complex needs. Building the necessary bridges presents challenges, but partnerships on the ground today demonstrate that Medicaid and housing policy and program officials with shared purposes can devise strategies to meet them.

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.*