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INSIGHT

An Information Resource from COMCARE

A Message of Good News

COMCARE hosted a community roundtable for elected officials and county leaders on March 21st, 2019 at the Lehigh Carbon Community College Alumni Center for Lehigh, Northampton, Berks, Schuylkill, Carbon, Monroe, and Pike Counties. Charles Curie[1] lead the discussion of an overview of Behavioral HealthChoices 20-year record of success.

Mr. Curie presented "a message of good news" – that the Pennsylvania Behavioral HealthChoices Program has been an overwhelming success with "cutting edge thinking on a national level that is occurring right now in Pennsylvania."

While many states throughout the country are changing their behavioral health delivery models, there is really none comparable to what has already been accomplished in Pennsylvania. Behavioral HealthChoices (B-HC) has developed a strong platform since 2009 for holistic healthcare with demonstrating effective integration of behavioral and physical healthcare.

Mr. Curie elaborated on how every county that had taken....

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[1] Charles Curie, a former Bush-appointed and U.S. Senate-confirmed Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) and former deputy secretary at the PA Department of Public Welfare (now the Department of Health & Human Services). Mr. Curie established the innovative Behavioral HealthChoices Program 20 years ago. Behavioral HealthChoices became a nationally acclaimed program for behavioral health managed care.

Charles Curie at the community roundtable for elected officials and county leaders on March 21st, 2019 at the Lehigh Carbon Community College Alumni Center.

"Cutting-edge thinking on a national level is occurring right now in Pennsylvania!"

-Charles Curie

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...their right of first opportunity has succeeded in a program of innovation in specialized healthcare. B-HC has increased access to care and service quality, providing better services to more Pennsylvanians while at the same producing billions of dollars of cost savings through close financial management of state and county governments.

Pennsylvania is far ahead of many states throughout the country who are just now tackling the challenges to transition away from state Medicaid "fee-for-service" programs. Pennsylvania left that model of inefficiency and cost-escalation back in 1997 with the implementation of the B-HC program.

What makes Pennsylvania truly unique, however, is that the B-HC managed care program is that it is administered by counties. Counties know best the nuances and needs of their communities and can skillfully leverage their local human services resources meet the essential social determinants of health for their citizens.

The "cutting-edge thinking" that Mr. Curie spoke of has produced advancements in integrated healthcare, incorporation of social determinants of health (i.e. housing infrastructure, employment) in the delivery of whole-person care and building value-based purchasing arrangements to move quality and cost savings forward.

Specific to integrated care, Mr. Currie said, "integrated physical / behavioral health has been demonstrated in Pennsylvania [within the B-HC program]. Integrated care is how the system touches the person, and how the person touches the system." Regarding proposals to carve B-HC back into physical health plans here in Pennsylvania, he said, "It has not been demonstrated that integrating behavioral health into a single-payer model (i.e. carving-in) has produced demonstrated results."

This view is shared by OpenMinds, in a recent executive briefing on whether integrated financing models (i.e. carved-in, single payer) work. Their opinion:

> *There is a lot of research on the benefits of physical and behavioral health integration at the clinical level,* ***there isn't a lot of research on behavioral health and physical health financial integration****.*[2]

On the national level, there are still an abundance of unknowns. Clearly there is no compelling evidence to show that carving specialized behavioral health programs into larger physical health plans produces results to warrant the disruption of a successful delivery model to over 2.9 million Pennsylvanians.

Regarding B-HC's demonstration of consistent performance, Mr. Curie said, "the outcomes are compelling!"

[2] Mandros, A.; Do States Still Have Medicaid Behavioral Health Carve-Outs?; OpenMinds; Executive Briefing, 2/21/19

Behavioral Health Financing Models – Understanding the Differences

Between 2011 and 2019 there have been major changes in behavioral health financing arrangements. Nationally, Medicaid health plans have trended towards integrated financing models. Other states have chosen to depart from specialized "carve-out" payment models, and the reasons vary state by state. We compare several Medicaid behavioral health financing models in Table 1 (below).

Pennsylvania has modeled success and innovation in the delivery of behavioral health services, evolving into one of the most successful models in the country. County legislators, human services administrators and community service providers celebrate the success of this program and are occupied with building creative integrated "whole-person" healthcare solutions for the people they serve. Yet, there is a challenge to dismantle and end this valuable program.

Medicaid financing of integrated care is at the center of the discussion. It is believed by some legislators that Pennsylvania will achieve greater cost savings and healthcare integration by bringing (i.e. carving - in) behavioral health services under larger Medicaid physical health plans. *Continued on page 4*

Table 1 – Medicaid Financing of Behavioral Health Benefits

Pennsylvania Behavioral HealthChoices (B-HC) operates under a primary carve-out, administered through counties who have assumed risk, and sub-contract with behavioral health managed care organizations. Proposed legislation in the General Assembly of Pennsylvania – House Bill #355 and Senate Bill #268 – seeks to eliminate the B-HC program. It may be helpful to understand the financing options impacting the debate. Provided below are brief descriptions of the 3 basic financing models used for Medicaid behavioral health services nationally:[3]

Traditional Specialty Carve-Out	Integrated Financing Carve-In	Vertical Consumer-Specific Specialty Carve-Out Plan
A primary carve-out model means that the payer (Medicaid) excludes behavioral health services from the primary financing arrangement for covered services. Some states operate a primary carve-out with all behavioral health services paid through fee-for-service by the state. The Pennsylvania specialty carve-out model in Behavioral HealthChoices replaced the old "fee-for-service" model in 1997, administering the program through counties, subcontracting with behavioral health managed care organizations.	Integrated financing means that responsibility for all behavioral health benefits lies with the Medicaid health plans. Integrated financing in Medicaid FFS plan – The state Medicaid program retains responsibility for all behavioral health and physical health benefits. This is the model proposed in the pending legislation to provide for behavioral health and physical health integration implemented by contracting with managed care organizations.	Primary vertical carve-out – State Medicaid program delegates responsibility for all benefits (physical health and behavioral health) for consumers with behavioral health disorders (or other specific disorders or needs) to a specialty care management organization (CMO). Differing from the traditional specialty which is responsible for identified behavioral health services, the new vertical specialty plan does not carve-out a specific set of benefits or services, rather it separates consumers into groups that have specific needs.

[3] Information provided in this table excerpted from: State Medicaid Behavioral Health Carve-Outs: The OPEN MINDS 2019 Annual Update, Market Intelligence Report; February 2019; and, Mandros, A.; The Medicaid Vertical Carve-Out Model Comes to I/DD; OpenMinds; Executive Briefing, 3/7/19.

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As B-HC and the integration options for physical and behavioral health are debated, there are several core considerations:

- What is clear is that Pennsylvania's B-HC county-based program and financing arrangement has demonstrated a model of quality and financial success for over 22 years, impacting over 2.9 million people and their families. Disruption of the B-HC program would cause undue hardship if not absolutely warranted with evidence of clear need.
- Are national trends and the conditions found in other states comparable to what we have developed and experience in Pennsylvania? It is difficult to make direct comparisons between programmatic and financing models because the conditions affecting states differ widely.
- We must be driven by hard data and proof from actuarial modeling in order to justify the complete overhaul of the current program. Mere assertions are not enough. Further, it must fit Pennsylvania's unique service delivery system.

- We can use the current debate to fuel meaningful discussion to better integrate physical and behavioral health to support more complete and holistic models of value-based purchasing. Rather than dismantling and disregarding program achievements, we should build upon them and develop integrated healthcare solutions.
- In the meantime, we can continue to look for ways within the carve-out model to coordinate care planning, communication and treatment, establish methods of essential data exchange – simplify and standardize process, and focus on quality outcomes.

The Nation's Public Health Insurance Program for People with Low Income

Medicaid is the nation's public health insurance program for people with low income. Nationally, the Medicaid program covers 1 in 5 low-income Americans, including many with complex and costly needs for care. The program is the principal source of long-term care coverage for Americans. The vast majority of Medicaid enrollees lack access to other affordable health insurance. Out of an estimated 12.6 million people in Pennsylvania, 26% are defined as low income, falling below 200% of the federal poverty levels, and 19% are covered by Medicaid and CHIP.

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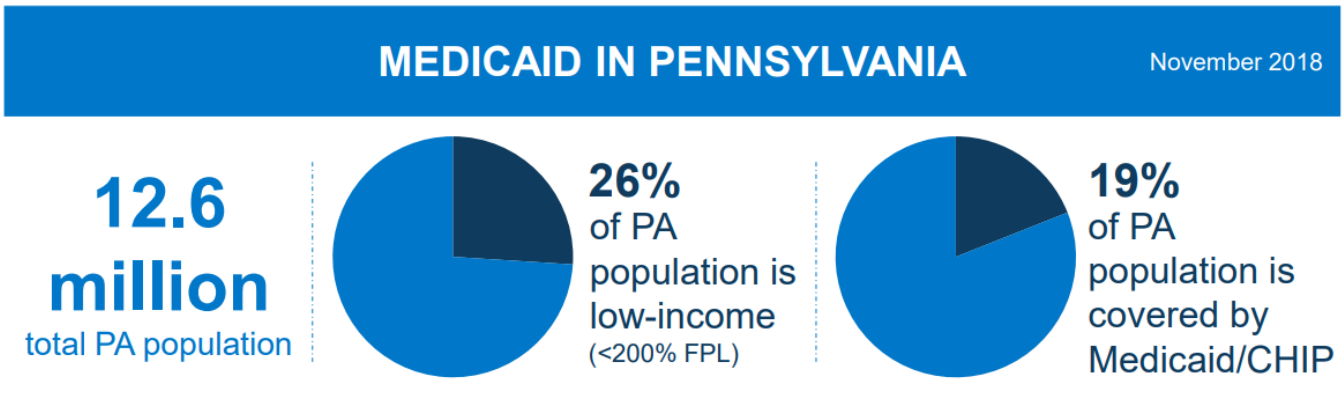

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Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. Medicaid finances nearly a fifth of all personal health care spending in the U.S., providing significant financing for hospitals, community health centers, physicians, nursing homes, and jobs in the health care sector.

Subject to federal standards, states administer Medicaid programs and have flexibility to determine covered populations, covered services, health care delivery models, and methods for paying physicians and hospitals. States can also obtain Section 1115 waivers to test and implement approaches that differ from what is required by federal statute but that the Secretary of HHS determines advance program objectives. Because of this flexibility, there is significant variation across state Medicaid programs.

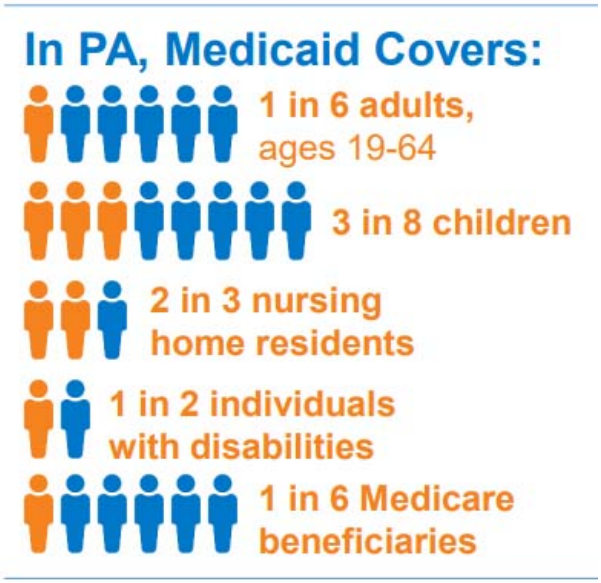
Medicaid has evolved over time to meet the requirements of the original 1965 Medicaid law, as well as to meet the particular needs of each state's population. States were afforded the opportunity to jointly craft programs that served their citizens best. Throughout its history, Medicaid has expanded to meet specialized needs – the most recent being the passage of the Affordable Care Act (ACA) in 2012.

As Medicaid plays a large role in both federal and state budgets and is the primary source of coverage for low-income Americans, it is a constant source of debate. Efforts to repeal and replace the ACA also included fundamental reforms to Medicaid to cap federal financing through a block grant or per capita cap. Such proposals were narrowly defeated in 2017.

Important Medicaid issues to watch in 2019 include Medicaid expansion developments and continued focus on changing the program through Medicaid demonstration waiver activities, including those focused on work requirements and other eligibility restrictions as well as potential waivers to reshape Medicaid financing.

In addition, other areas in Medicaid to watch are reforms in benefits, payment and delivery systems, efforts to address social determinants of health, efforts to control prescription drug costs, and expand capacity to address the opioid epidemic and provide community based long-term care services.

Excerpted from: Rudowitz, R. et. al; 10 Things to Know About Medicaid: Setting the Facts Straight; Kaiser Family Foundation; March 6, 2019; and Medicaid State Fact Sheets; Kaiser Family Foundation; September 27, 2018.



Some Medicaid Facts:

- *The Medicaid entitlement is based on two guarantees: first, all Americans who meet Medicaid eligibility requirements are guaranteed coverage, and second, states are guaranteed federal matching dollars without a cap for qualified services provided to eligible enrollees.*
- *Total federal and state Medicaid spending was $577 billion in FY 2017. Medicaid is the third-largest domestic program in the federal budget, after Social Security and Medicare, accounting for 9.5% of federal spending in FY 2017.*
- *In 2017, Medicaid was the second-largest item in state budgets, after elementary and secondary education.*
- *Federal Medicaid matching funds are the largest source of federal revenue (55.1%) in state budgets.*
- *Accounting for state and federal funds, Medicaid accounts for 26.5% of total state spending.*
- *Pennsylvania spends $28.3 billion in Medicaid with 52% going to managed care, 36% to long-term care, and 12% to acute care, hospital payment and Medicare premiums.*

Creating A Treasure Trove of Data for Health Plans

Today, health plans gather and report data for many purposes. They require physician practices to report data from health records for quality reporting and collect diagnoses from claims and other sources to support risk adjustment. They also use data from these sources and others for population health and care management initiatives by identifying individuals at risk for high health care spending. Often these functions are separate and uncoordinated.

While many health plans have taken steps to sort the data treasure from the junk, the system, reporting activities, and people using the data are, for the most part, disconnected.

Deloitte Center for Health Solutions (Deloitte) has identified two types of opportunities for health plans to manage this data more efficiently over the next three to five years. Health plans should:

- Coordinate the data and processes at the functions that support data with an enterprise-wide strategy; and,
- Automate aspects of data collection and reporting using tools like robotic process automation (RPA), natural language processing, and artificial intelligence (Al).

The Current State

Deloitte asked leaders to reflect on their operations, and how they collect, manage, organize, and use health data with the response being that data is often duplicative and not well-aligned. Abstracts are created from claims and enrollment data, but very few are using social determinants of health (See figure below). Furthermore, respondents said their risk adjustment, quality, and care management functions are partially or totally segregated. Finding the right-fitting technology solution (i.e. build it or buy it) to develop capabilities continues to be a challenge – because there is no "one-stop-shop" vendor that is helping organizations do a complete assessment of their data, people, and processes.

Few organizations use non-health data to inform risk and quality measurement or care management

	Risk adjustment	Quality/STAR ratings	Care management
EMR abstracts	MOST		
Electronic EMR feeds	LEADING		
Claims data	MOST		
Enrollment data	MOST		
In-home assessment data	MOST	FEW	LEADING
Disease management program data	LEADING	LEADING	MOST
Patient lifestyle information (e.g., shopping patterns)	FEW		
mHealth data	FEW		
Remote monitoring devices	FEW		
Survey data (e.g., patient experience)	FEW		

Source: Deloitte analysis of responses during qualitative interviews.

Most organizations are still trying to determine how emerging technologies will play into their future analytics strategies – focusing on capitalizing on the potential of the technology they already have before investing in something new. More telling is that it is more important putting in place the right people and processes to make the most of their current technology is more important in the short term than adopting the newest and greatest technology.

Improving Efficiencies in the Short-Term

How can health plans take steps toward the future—a world where data is seamlessly coordinated and continually updated? They can start by organizing more efficiently around the current systems in place. Health plans should consider applying an enterprise-wide approach to understanding where the data is, overhauling current processes to optimize the flow of data, and adopting emerging technologies to further enhance their performance.

Query the functions on typical touchpoints, areas of overlap, and how they can be streamlined. Health plans and the providers participating within their networks are swimming in a sea of patient data that is unconnected, unorganized, and sometimes unusable. Develop a streamlined approach to collect data from and target services to members. Find and collect new data sources.

Regarding optimal data flow - take an enterprise approach to integrating data, people, technologies, and processes. Assess, or build if necessary, programs and methods to engage clinicians and provider organizations; developing clinician-level analytics to understand treatment, prescribing, referral and coding patterns. Leverage relationships in advanced markets where provider organizations have stronger alternative payment model capabilities and build incentives into new payment arrangements. Develop compliance programs of the future to manage risk and use emerging technologies that drive ROI and value. As these emerging technologies allow for more data aggregation and automation of tasks, leaders must assess skill gaps and develop new roles and skill sets.

What the Future May Hold

Looking forward to 2040, we predict that the health care system we know today will look completely different. We envision a future of health wherein, by using actionable health insights driven by radically interoperable data and AI, we should be able to identify illness early and intervene much more quickly. This can pave the way for a future focused more on well-being rather than treatment.

In the future of health, the "always-on," sensor-driven environment will generate massive amounts of data—data that is continuously gathered and stored by multiple owners and selectively made available. The data will come from traditional players—health plans, providers, government regulators—and nontraditional players—digital giants, retailers, consumers. This kind of radical interoperability will enable seamless integration of multiple, disparate data sources and applied advanced analytics to derive real-time insights to improve the patient experience and drive the delivery of "always-on" care.

Excerpted from: Judah, R., et. al.; Creating A Treasure Trove of Data for Health Plans – Shifting Focus from Disparate Systems to a Connected Future; Deloitte Insights; April 12, 2019.

Final Thoughts…

You can achieve all the things you want to do, but it's much better to do it with loved ones around you; family and friends, people that you care about that can help you on the way and can celebrate you, and you can enjoy the journey. – John Lasseter

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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.*