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INSIGHT

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Spotlight: Berks County HealthChoices

In a recent paper entitled "Behavioral HealthChoices Carve-Out Model in PA: Revisiting the Success Story", Dr. Edward Michalik, MH/DD Administrator, Lydia Singley, HealthChoices Program Director, and James Myers, Community Care Behavioral Health Regional Director outline the successful model in Berks County.

Berks County operates under a behavioral health managed care organization human services integration model (Integration Model). This model successfully addresses the various behavioral health and social services needs of the Medicaid population, and efficiently streamlines resources and reduces health care costs. In the integration model, the behavioral health managed care organization (BHMCO) works for the county and collaborates closely with county-based human services agencies for all Medicaid enrollees.

The Berks County human services agencies coordinate and address their members external social determinants of health leveraging the combined strengths of county resources and the Behavioral HealthChoices Program (B-HC) to build a high-quality of care "safety net". The Integration Model also works at the member level with their respective physical health managed care organization promoting integrated healthcare without duplication of resources. (See Figure 1).

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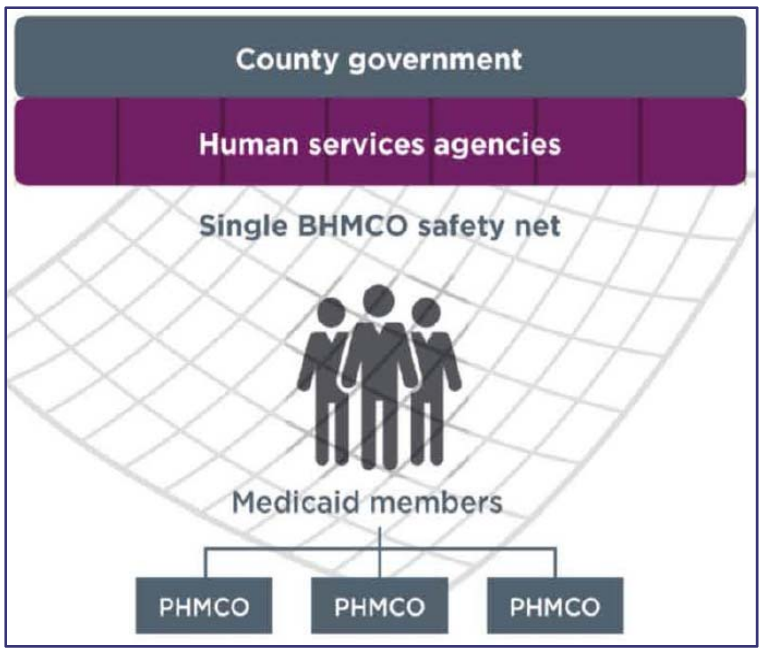

Figure 1 - Berks County Integrated Model (Current Statewide Model)

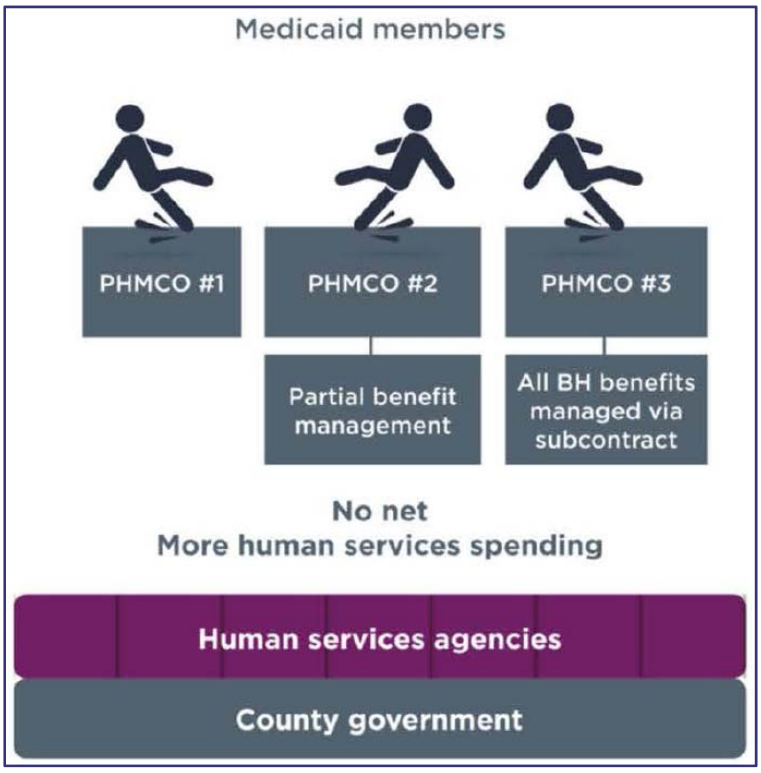

Figure 2 - Newly Proposed "Carve-In" Model

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House Bill 335 (HB335) and its counterpart in Senate Bill 268 (SB268), introduced in the Pennsylvania General Assembly in February 2019 seeks to integrate behavioral and physical health services by removing the successful model now being used by Berks County, and all other counties throughout Pennsylvania.

While the proposed legislation affirms appropriate goals[1], it implies that these goals do not currently exist under the current B-HC delivery model. On the contrary, B-HC has been successfully meeting these same goals for over 20 years, providing a solid foundation for continued integrated healthcare delivery.

The newly proposed model envisioned by HB335 and SB268 tears down current model described above. In the new model, Pennsylvania contracts directly with multiple physical health managed care organizations (PHMCO) to manage both physical and behavioral health benefits. PHMCOs would then in turn contract with BHMCOs, and neither organization would have a contractual agreement with local county government, or a close coordination with their valuable human services resources.

With this new model, the contractual ties – or "safety net" – linking the county, state, and federally funded human services agencies along with Medicaid managed care would be lost (See Figure 2). The result is less coordination of physical and behavioral health care, reduced focus on comprehensive treatment of individuals, and potentially higher health care costs stemming from treatment of symptoms instead of the underlying behavioral health conditions that contribute to physical health challenges. *Continued on Page 3*

[1] HB 335 and SB 268 include language: 1.) that each recipient receives high-quality, comprehensive health care services in the least restrictive setting; 2.) incorporating strategies to address social determinants of health; 3.) providing optimal information exchange to support whole-person care; 4.) provide for budget stability with defined outcomes and accountability; 5.) balancing the needs of quality healthcare services, patient satisfaction, prudent financial measures and self-sufficiency; 6.) ensuring efficient and cost-effective care and administrative systems and structures; 7.) a sustainable and uniform delivery system, and; 8.) promoting independence and self-care.

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Often disruption to the current way things are done can become very helpful and productive. The development of innovative holistic care is a goal all stakeholders throughout the state can embrace.

Berks County has demonstrated a long history of growth and innovation, building the foundation of integrated holistic care upon the B-HC program – improving quality and access to Medicaid behavioral health services while containing costs.

In addition, enhanced coordination under the human services integration model saves billions by addressing the social determinants of health and is critical to attacking the overdose epidemic.

With the proposal of dramatic and sweeping changes within the state, where potential outcomes and unintended consequences are hard to define, Berks County uses the guiding principle "First, do no harm" for program evolution going forward, ensuring that the wide-ranging gains achieved by HealthChoices serve as a sound foundation for promoting increased value for Pennsylvania's vulnerable Medicaid population.

The B-HC Program is a health policy success story clinically, financially, and in its positive impact on those who rely on Medicaid for treatment of behavioral and physical illnesses. The single point of coordination between the BHO and county government human service programs on one side, and BHO and behavioral provider network on the other, has provided a rational, efficient, and high-functioning system with excellent outcomes in all dimensions. Retaining the human services integration program not only meets the ethical principles to do no harm but allows for the continued evolution of the system to pursue and achieve the next level of care integration, quality, and cost management.

Some quick facts...

- *Community Care has partnered with local county authorities to serve over 1 million Medicaid recipients in 39 counties across the Commonwealth and began working with Berks County in 2001.*
- *Berks County Behavioral HealthChoices enrollment has increased each year, and while the percentage of enrolled beneficiaries receiving behavioral health services has nearly doubled from 14% to 24%, the average cost per member using service has dropped by 30%.*
- *In fiscal year 2016-2017, Berks County HealthChoices had 88 thousand enrolled covered lives, providing services to over 21 thousand for $82.5 million dollars.*
- *To date, $26.3 million dollars of reinvestment funds have been used to implement new innovative services.*

Pennsylvania Model is Outperforming National Standards for Integrating Care

Comorbid physical and behavioral health conditions result in increased functional impairment and increased health care costs. Community Care and other BHOs manage the whole person successfully and have Pennsylvania in the top quartile of states nationally in positive care quality outcomes on national measures that rely on coordinating physical and behavioral health based on FFY 2016 Children's and Adult Health Care Quality Measures.

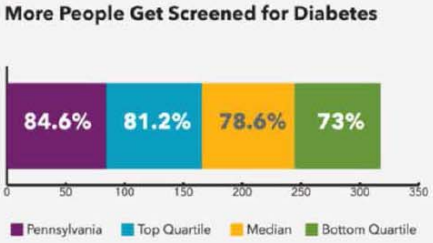

Figure 4: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications: Ages 18-64

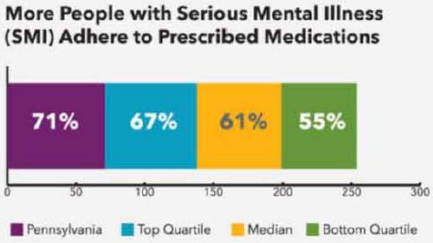

Figure 5: Schizophrenia Diagnosis Dispensed & Remained on Antipsychotic Medication for At Least 80% of Their Treatment Period: Ages 19-64

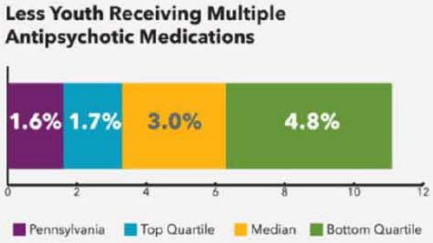

Figure 6: Limiting the Use of Multiple Concurrent Antipsychotics in Children & Adolescents: Ages 1-17 (Lower rates are better)

Figure 4 and Figure 5 display positive results for both diabetes screening and medication adherence for persons with schizophrenia. Figure 6 illustrates the success in minimizing the use of multiple antipsychotics in children and youth with serious emotional and behavioral conditions.

These successes are achieved by Pennsylvania DHS deploying comprehensive physical and behavioral claims made available to both BHOs and PHOs. This information access has supported successful care integration programs like the Behavioral Health Home Plus (BHHP). Local county authorities and Community Care have impacted BH-HC beneficiaries' health and wellness through the BHHP program.

Figure 7 provides an example of access-to-care success, with 83% of BHHP beneficiaries surveyed reporting having visited their PCP in the past six months.

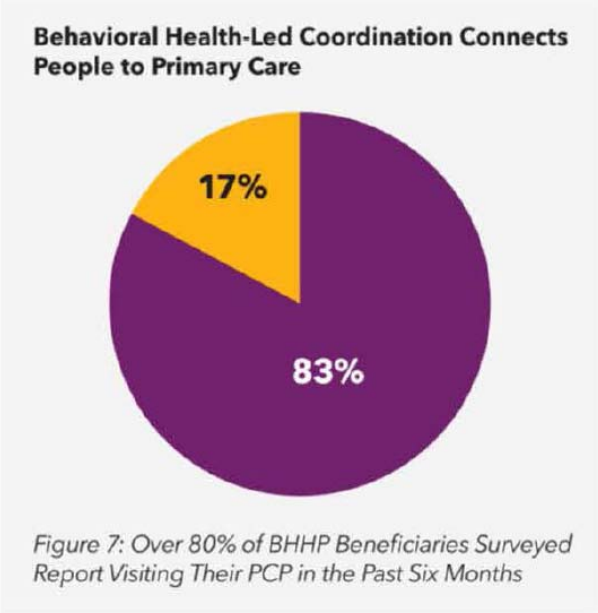

Figure 7: Over 80% of BHHP Beneficiaries Surveyed Report Visiting Their PCP in the Past Six Months

Excerpted from: Michalik, E. et. al., Behavioral HealthChoices Carve-Out Model in PA: Revisiting the Success Story; Berks County HealthChoices and Community Care Behavioral Health Organization; February 2019.

Medicaid: What to Watch in 2019

Medicaid, the provider of health insurance coverage for about one in five Americans and the largest payer for long-term care services in the community and nursing homes, continues to be a key part of health policy debates at the federal and state level. Important Medicaid issues to watch in 2019 include Medicaid expansion developments amid ongoing litigation... *Continued on Page 5*

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...about the Affordable Care Act (ACA's) constitutionality as well as Medicaid demonstration waiver activities, including those focused on work requirements and other eligibility restrictions. Reforms in benefits, payment and delivery systems continue to evolve as states and the federal government focus on managed care, social determinants of health, prescription drugs, and community based long-term care.

Medicaid Expansion

Medicaid expansion was an important issue in the 2018 midterm elections. Following the election, 37 states including the District of Columbia have adopted the ACA's Medicaid expansion. Pennsylvania adopted and implemented Medicaid expansion as of 1/1/2015. Many studies on the effects of the ACA Medicaid expansion point to positive effects on coverage, access to care, service utilization, and state budgets and economies. It is yet unclear if more states will move to adopt the Medicaid expansion in 2019, and if the current states will make changes to their programs? Also, will pending litigation of the constitutionality of the ACA have implications for Medicaid expansion?

Medicaid Waivers

Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid not otherwise allowed under current law, provided the demonstrations meet the objectives of the program. States are implementing and proposing waivers that include work requirements for eligibility, as well as other eligibility restrictions. Currently, Kentucky and Arkansas (two states implementing eligibility restrictions) are in litigation. Other states are watching and learning as the outcome of litigation is known.

Medicaid Initiatives to Address the Opioid and Substance Use Disorder Crisis

Medicaid covers 4 in 10 nonelderly adults with opioid addiction. Medicaid facilitates access to treatment by covering numerous inpatient and outpatient treatment services, as well as medications prescribed as part of medication-assisted treatment (MAT). States continue to focus on strategies to address the opioid crisis. All states are implementing pharmacy benefit management strategies including quantity limits, prior authorization requirements, and requirements for Medicaid prescribers to check their state's Prescription Drug Monitoring Program before prescribing opioids to a Medicaid patient.

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act was signed into law in October 2018. While very broad in scope, the final legislation contains a number of provisions related to Medicaid's role in helping states provide coverage and services to people who need opioid use disorder (OUD) and other substance use disorder (SUD) treatment, including a time-limited option that allows federal Medicaid payments for enrollees with SUD in institutions for mental disease (IMDs), available to states beginning in October, 2019.

Medicaid Financing for Puerto Rico and the US Virgin Islands

The February 2018 federal budget bill provided increased financial support fo r Medicaid in Puerto Rico and the U.S. Virgin Islands (USVI) in the aftermath of hurricanes Maria and Irma. The budget bill increased the federal

caps for Puerto Rico ($4.8 billion) and USVI (approximately $142.5 million) and provided Medicaid funds at 100% federal match from January 2018 through September 2019, as these territories continue to recover from Hurricanes Maria and Irma. However, federal legislation will be required to avert a financial cliff when the Medicaid financing support expires at the end of September 2019.

Medicaid and Public Charge Changes

Changes have been proposed to long-standing "public charge" policies. The federal government can deny an individual entry into the U.S. or adjustment to legal permanent resident (LPR) status (i.e., a green card) if he or she is determined likely to become a public charge. Under the proposed rule, officials would newly consider use of certain previously excluded programs, including Medicaid, the Supplemental Nutrition Assistance Program, the Medicare Part D Low-Income Subsidy Program, and several housing assistance programs, in public charge determinations. The changes would likely lead to broad decreases in participation in Medicaid and other programs among legal immigrant families and their primarily U.S.-born children beyond those directly affected by the changes. A final rule is still pending.

Medicaid and Payment and Delivery System Reforms

Risk-based managed care continues to be the predominant delivery system for Medicaid services, and states are focused on implementing alternative payment models, improving quality within MCOs and developing initiatives to address social determinants of health. Nearly all states are employing one or more strategies to expand the number of people served in home and community-based settings, and states have initiatives to address long-term services and supports (LTSS) workforce issues. Housing-related supports remain an important part of state LTSS benefits, and states are working to maintain housing-related supports even as Money Follows the Person (MFP) grant funds expire. It will be very interesting to see Medicaid's role in addressing social determinants of health.

Final Thoughts…

The law of unintended consequences, often cited but rarely defined, is that actions of people—and especially of government—always have effects that are unanticipated or unintended. Economists and other social scientists have heeded its power for centuries.

Famous French economic journalist Frederic Bastiat distinguished between the "seen" and the "unseen" – he wrote: "There is only one difference between a bad economist and a good one: the bad economist confines himself to the visible effect, the good economist takes into account both the effect that can be seen and those effects that must be foreseen."

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.*