HEALTHCHOICES AS A MODEL –
Behavioral Health Managed Care… More than Just a Carve Out

In 1997, a change started in the administration and funding of behavioral health services for individuals eligible for Medicaid. The "right of first opportunity" was offered to counties and the behavioral HealthChoices program was rolled out. The "right of first opportunity" permits counties to contract and oversee Medicaid funded behavioral health managed care contracts. As the rollout continued through the state, the Department of Public Welfare executed behavioral health contracts for the counties that did not or could not opt to exercise their right of first opportunity. In 2007, this approach to Medicaid behavioral health services was statewide. Although this approach appears antithetical to integration, the actual service delivery system is demonstrating increased collaboration, integration and maximization of funds.

Savings

Traditionally, managed care contracts that include behavioral and physical health are contracted to a large physical health managed care organization (MCO). The physical health MCO then subcontracts with a behavioral health MCO. In this approach, administrative dollars and profits are realized at two contract levels. When counties hold the managed care contracts for behavioral health, there is no physical contractor taking their portion of administration and profit resulting in more dollars going to provide direct services. Regardless of who oversees the plans, all behavioral health managed care contracts must meet the state set standards, which are available online at:
http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002381.pdf

Counties that receive funds to oversee behavioral health MCO contracts receive substantially lower payments for the oversight than with private contractors. If there are earnings or profits realized locally from the county held MCO contract, a portion of the funds may be dedicated to local reinvestment solely dedicated to improve, expand or support services to individuals in the plan rather than used for stockholders or bonuses as is common practice in the for-profit sector.

Leverage

Reinvestment funds require approval from the Department of Public Welfare's Office of Mental Health and Substance Abuse prior to spending the funds and are critical to the success of the program. Reinvestment funds are not permitted to create future liabilities or ongoing future expenses. There are numerous ways to further support individuals with mental illness to assist developing community supports and services within these confines.

Housing is an excellent example that demonstrates how reinvestment funds can leverage additional funding to support individuals with mental illness. Between 2005 –2010 a total of $52,133,472 was used as one time funding from local reinvestment funds to create local housing options. Reinvestment funds made it possible for counties to partner with their county mental health office, county development offices, local housing agencies, Pennsylvania Housing Finance Agency and the Technical Assistance Collaborative to create a stable home necessary for individuals recovering from mental illness. By leveraging reinvestment and other funding streams over a dozen counties collectively realized 1600 units.

Leveraging takes on many different forms depending on the local needs. Throughout the state there is one mutual way that leveraging occurs: to create critical services that benefits all individuals in their efforts for recovery. Through reinvestment dollars services that previously were not available are created to meet contract standards or local needs. These services can benefit individuals who are not funded through

Medicaid, but are paid through other funding streams. Reinvestment can make it possible to address the Medicaid population and assist in addressing the needs of other individuals with mental illness solely by expanding the options of services available!

Creating new approaches

Throughout the country, especially in rural areas like Pennsylvanian, securing psychiatric care in the community is difficult. Reinvestment dollars are being used to create telepsychiatry which can provide psychiatric diagnostic assessment, evaluation and medication management. Telepsychiatry not only decreases waiting time in accessing care, but increases the number of individuals seen by a psychiatrist and supports collaboration with other professionals involved.

New approaches also include the continued efforts to incorporate new services with amendments to the State Medical Assistance Plan. All programs now have a choice of a Certified Peer Specialist, which is someone who has experienced mental illness or chemical dependence and assists others to sustain living and working in the community. The local oversight agencies are increasingly creating new evidenced based practices including:

- Assertive Community Treatment
- Supported Housing
- Family Psychoeducation
- Integrated Treatment for Co-occurring disorders
- Illness Management/Recovery
- Medication Management

Collaboration and integration

Creating new approaches and evidenced based practices frequently rely on collaboration either at the family level or between systems. An area of demonstrating effective collaborative and continued efforts is the reduction in the use of placing children in residential treatment facilities. One project formed documented their efforts to convene a work group with all county child-serving systems to develop an action plan for a fully integrated local system of care for children and reducing of children residing in facilities. By incorporating all the available resources and addressing all the children in facilities regardless of what system is funding the placement, the number of children in out of home placement was reduced by 57% and provided community based services.

Collaboration continues to spread in many venues; forensics, child welfare, education, behavioral health, substance abuse services are crossing traditional boundaries. Schools have behavioral health programs. Outreach to older persons needing mental health services is occurring. Behavioral health is creating care management to collaborate with traditional medical practitioners. Multi-systemic approaches to respond to community needs continue to grow to meet the demands while operating under the focused constraints of programs.

Successes

Behavioral Health Choices with the “carve out” of behavioral health managed care permitting the counties the “right of first opportunity” has exceeded performance standards in numerous areas. Each contract area has their strengths and challenges and learns from each other new perspectives and options for solutions. Behavioral health under the HealthChoices carve out is meeting with success beyond the three stated goals for the Department of Public Welfare: 1) improve access to health care services for

Medical Assistance recipients; 2) improve the quality of health care to Medical Assistance recipients and 3) stabilize Pennsylvania's Medical Assistance spending. There is much more from the behavioral health carve out as the successes continue to grow beyond the initial standards. Some of the notable successes include:

- Collaborative planning with local partners, both public and private to reach outcomes
- Identifying approaches to meet local needs
- Creating more evidence based practices
- Breaking records for access to services for chemical dependence
- Promoting individual choice and voice in services and supports through recovery-oriented practices
- Creating high consumer satisfaction
- Decreasing the need for admissions to inpatient care through community services and support

RECOMMENDATIONS

Understanding that the state needs to find new ways to deliver care and services, and to find things that can sustain programs, CCAP suggests that the Commonwealth approach these new funding mechanisms on a pilot basis. By starting first with several willing counties and testing the new approach, permits the state to make revisions in order to assure that goals and outcomes are met.

Counties are partners. Counties are gate keepers, Counties know their constituencies and providers, and are better able to manage locally directed programs. Counties can provide the state with administrative infrastructure needed to reduce the state's bureaucratic burden.

Consider the benefits in assuring flexibility and effective use of funds through HSDF, and maintain the structure of the act to create a new mechanism to develop flexibility. Use it for a structure for collecting funds from categorical and other programs that have gone unspent. This mechanism could be utilized to redirect under spent dollars to counties that are overspent and in need of funding to address unforeseen needs.

Any changes in the system must be developed in collaboration between the state and counties. While we maintain that any significant change will be difficult, those arrived at through discussion, and implemented carefully, first in a few pilot counties before moving statewide, are likely to produce the best outcomes. CCAP stands ready to work with the administration.