



PACA MH/DS
PENNSYLVANIA ASSOCIATION OF COUNTY
ADMINISTRATORS OF MENTAL HEALTH
AND DEVELOPMENTAL SERVICES

July 15, 2015

April Leonhard
Department of Human Services
Office of Long Term Living, Bureau of Policy and Regulatory Management
P.O. Box 8025
Harrisburg, PA 17105-8025

Dear April Leonhard:

Thank you for the opportunity to publicly discuss the Managed Long-Term Services and Supports (MLTSS) in Pennsylvania. PACA MH/DS is offering recommendations that reflect our members' vast experience in developing and implementing community services. PACA MH/DS members include the county MH/ID administrators and oversight behavioral HealthChoices agencies statewide.

Our organization supports a participatory role for county government in the development of all state human services policy, including the right of first opportunity for local management of managed care for behavioral and intellectual disability services. The MLTSS discussion document does not fully discuss the currently successful carve out for behavioral health services under HealthChoices which includes the local delivery and management of mental health and substance abuse services. PACA MH/DS believes the current HealthChoices Behavioral Health program is a success on which to build upon as the Commonwealth works to develop long term care services and supports.

The MLTSS Goals and Objectives reflect the continued development of the HealthChoices Behavioral Health (HC-BH) program. The HC-BH program model has clearly shown counties' ability to meet the goal of containing Medicaid costs while simultaneously improving quality and access to care. The MLTSS proposal targets a specific vulnerable population who are dual eligible for Medicare and Medicaid who do not reside in institutions. The population profile clearly indicates the imperative to have a carefully coordinated management plan to meet the significant and chronic care issues of these individuals. It will also be important when contemplating program design to explore the similarities and differences of segments within the population and essential to consider the differences in the aging sector and all others who are dually eligible.

In *Medicare-Medicaid Enrollee State Profile: Pennsylvania – the 2008* statistics demonstrate the need for addressing the mental health concerns of individuals who are dual eligible. The population statistics from this report (Table 2) indicate that dually eligible (with full benefit – 325,471 individuals) conditions include serious mental illness:

AN AFFILIATE OF THE COUNTY COMMISSIONERS ASSOCIATION OF PENNSYLVANIA

PACA MH/DS
PO BOX 60769
HARRISBURG, PA 17106-0769

(717) 526-1010 · PHONE
(717) 526-1020 · FAX
WWW.MHDSPA.ORG

Schizophrenia

- 14.4 percent of individuals under 65 and 13.2 percent for over age 65

Bipolar disorder

- 15.9 of individual under age 65

Personality disorder

- 3.9 percent under age 65

Depression

- 32.9 percent of individuals under age 65 and 28.7 percent for over age 65

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008StateProfilesPA.pdf>

County mental health programs and their respective HC-BH agencies *currently* manage the challenges associated with serving the target population. (*Medicare, Medicaid and Dual Eligible Challenges September 2013* attached). The issues surrounding this group are significant as limited county base mental health funds are available to assist and HC-BH operates under Medicare guidelines. Local agencies know the individuals involved and their families and understand the management and coordination skills required to provide quality care for such complex cases. The Capital Area Behavioral Health Collaborative, the HC-BH for five counties, provided the following chart of individuals in the target group currently being managed by their organization.

Capital Area Behavioral Health Collaborative

Aid Category	SSI w/ Medicare & Healthy Horizons
Date of Srvc-FY	FY 14/15

Child Adult	Age Category	Values		
		Members	Consumers	Penetration
Adult	Ages 18 - 20	96	30	31.25%
	Ages 21 - 44	5,953	2,000	33.56%
	Ages 45 - 64	8,895	2,388	26.80%
	Ages 65+	7,282	514	7.04%
Adult Total		21,684	4,838	22.28%

For the last 18 years HC-BH has consistently met the standards of care and satisfaction in providing community services to the target population. In fact, through HC-BH the service array has expanded beyond the required services outlined in the State Medical Assistance Plan (SMAP). PACA MH/DS is concerned that potential changes to the system could adversely impact individuals and their access to services. Individuals currently receiving a supplemental service to the SMAP would lose that service and the entire population is at risk of losing their current service provider. (See attached *HealthChoices Successes*). Supplemental services are made possible through county oversight agencies through the use of reinvested Medicaid funds.

Supplemental services have been successful in reducing cost and improving care to support persons in the community. Treatment options that are not “in-plan” Medicaid or Medicare services are possible due to the collaboration with the Office of Mental Health and Substance Abuse Services and are used to develop supplemental services and best practices.

The recent HealthyPA transition highlighted the need for continuity of services and clear messaging for consumers and providers during any implementation process. The challenges also provided an opportunity to showcase how the longstanding collaboration between PACA MH/DS and state organizations can be leveraged to address issues that can and will arise as new programs are designed and implemented.

Comments for specific areas identified in the Discussion Document are covered below.

Program Design

Stakeholder involvement in shaping the currently stated design is recommended on a larger scale than currently occurring in order to increase awareness and identify concerns in defining, planning and implementation.

Explore expansion of current HC-BH model to manage LTSS services and programs.

Design the program to be at the local level in order to mirror the HC-BH efforts of coordinating with the various programs such as work force development, developmental disabilities, court systems and other county departments. The local relations promote collaboration and integration, which enhances the ability to provide a person-centered approach to care and supports.

Expand on counties experience to move individuals from institutional care to the community as demonstrated using various funding as evidenced by HC-BH with CHIPP, base funds, reinvestment and other public funds.

Expand the coordination of care practices between physical and behavioral health under the current HealthChoices program with benchmarks and incentives. Pennsylvania has many examples of successful models of integrated care that engage primary care physicians, hospitals, pharmacies and other healthcare providers that would benefit the target LTSS population.

Gather expertise from private and governmental agencies with experience in serving this large non-homogenous population.

Designate savings in the program to be applied to serve more individuals.

Planning Phase

Clearly articulate the differences in two different consumer stakeholder groups in terms of services, system capacity, and impact on current services being received.

Research and examine current utilization and location of behavioral health services for current and future recipients of LTSS both in Fee-for-Service and managed care plans.

Identify and plan for individuals currently accessing supplemental behavioral health services to assure access and continuity of care.

Allow sufficient time for stakeholder review prior to implementation in order to gain best approach for recipient transition. (Recipients, providers, managed care organizations, families, caretakers, counties, etc.)

Research and capitalize on successes within the commonwealth and nationwide.

Complete an environmental scan of current behavioral health providers enrolled in Medicaid and/or Medicare to determine gaps.

Profile current target population to determine met and unmet needs.

Involve recipients in the review in all aspects and levels of the program.

Identify approaches to promote and support evidenced based and best practice models of service.

Model comprehensive readiness review after HC-BH model currently in practice.

Implementation

Allow sufficient time to prepare recipients, providers and governmental agencies to transition to new approach.

Do not permit behavioral health to be an adjunct service to a physical health system. Past experience indicates that physical health plans will create special units for behavioral health rather than building upon community provider capacity.

Clearly identify how outstanding claims (commonly referred to as a tail) will be covered during the transition from one service system to another.

Identify risk sharing arrangements that are acceptable and unacceptable.

Identify approach to incentivize desired system and recipient outcomes, including integration of physical and behavioral health services.

Explore the similarities and differences in the population served, essential considering the differences in the aging population and all others who are dually eligible.

Account for current savings made possible through HC-BH's unreimbursed coordination for individuals who are dually eligible.

If MLTSS proceeds separately from the current HealthChoices, adequate planning should be provided to address operational issues by current HealthChoices managed care organizations.

Oversight

PACA MH/DS supports local oversight in a partnership between state and local entities as has been viable for HC-BH in meeting or exceeding standards.

Quality

PACA MH/DS agrees with the MLTSS quality strategy components of MLTSS as stated. Again, HC-BH experience of monitoring in partnership and reaching out to consumers is essential as use of the Healthcare Effectiveness Data and Information Set (HEDIS) in the current HC-BH design.

Determine what rebalancing or effort is appropriate for individuals not in or not eligible for nursing home care.

Again, thank you for the opportunity to comment and hopefully fully discuss the MLTSS proposal. Clearly, our concerns regarding individuals with mental illness are a critical component in planning for the MLTSS program's success. PACA MH/DS believes that the accomplishments of the current HealthChoices for Behavioral Health Program can be expanded or transformed to create a viable community MLTSS.

Sincerely,



Lucy Kitner
Executive Director

cc: DHS Secretary Ted Dallas, OMHSAS Deputy Secretary Dennis Marion



Medicare, Medicaid and Dual Eligible Challenges

September 2013

Medicare and Medicaid create challenges to cover individuals with severe and persistent mental illness. The rules create complex circumstances that impede service delivery. Some of the challenges are noted below:

- There are few Medicare providers available statewide willing to accept the low rates and slow payment system.
- Increasingly, Medicaid providers are requesting payment to cover costs from mental health base funds when billing to HealthChoices (for dual Medicare/Medicaid beneficiaries), which is not permitted.
- Due to the lack of available Medicare substance abuse providers, HealthChoices pays the full cost of care to assure member access to services.
- Supplemental billing cannot proceed until the slow Medicare payment process is complete.
- Many individuals receiving outpatient mental health services are Medicare only increasing pressure on mental health base funds.
- CHIPP guidelines recommend HealthChoices dollars be used to provide services, but the majority of individuals are Medicare beneficiaries creating limits to the use of Medicaid. Medicare is the first payer, which has a low rate and slow payment system while Medicaid is payer of last resort and can only provide payment once Medicare payment processes are complete.
- Base mental health funds are needed to support the most disabled, which are individuals who are Medicare eligible as part of their Social Security Disability determination.



HealthChoices Successes

The current HealthChoices structure provides a single accountable entity at the local level to support building a unified system of care, common expectations for providers, common rates, and transparency to users of services. The HealthChoices structure also guarantees local stakeholder input into service development to address the unmet needs of people recovering from mental illness and addictive disease. The structure of the program assures a local presence in the BH MCO operations which results in a more personalized relationship, problem resolution and service enhancement.

TAXPAYER BENEFITS

Savings achieved if the cost of providing services is less than the capitation payments are reinvested in specialized community services based on local community needs, and this has resulted in the creation of private sector jobs at the local level. HealthChoices administrative dollars also help cover medical assistance related expenses that counties and local taxpayers have historically incurred.

CROSS SYSTEM PROBLEM-SOLVING AND FUNDING TO IMPLEMENT IT

The ability to design the service system at the local level has allowed the mental health, drug and alcohol, court system, district attorney's office, public defenders, adult probation, and district justice offices to come together to divert, step down and/or actively treat individuals with behavioral health needs who are entrenched in the criminal justice system. The availability of an expanded community-based behavioral health service system has facilitated a speedier inclusion into services.

DATA-DRIVEN LOCAL DECISION MAKING

Medical Assistance data is made available to counties monthly, and this data is used to make decisions and identify issues and trends. The data is being used on a county and regional level to evaluate services, plan for future needs, monitor outcomes and assist with strategic decision-making.

COORDINATION OF FUNDING

Prior to HealthChoices, the mental health and substance abuse service system has historically been funded through single funding sources divided up under the various service systems. There was little to no coordination of services provided under multiple funding streams. Now county programs are strongly involved in local and regional coordination of services and are finally in the position to manage all the behavioral health funds under one local management structure. Accordingly, the funds can be aligned to best meet the needs of persons as determined collectively and collaboratively at the local level, between all human services program areas.

REGIONAL COOPERATION TO ADDRESS LOCAL NEEDS

Counties work with BH MCOs to design and implement regional initiatives. If BH MCOs working with more than one county have identified regional needs, they have suggested initiatives and facilitated workgroups and committees to address those needs which include representation of providers and the counties. In the southwest zone, HealthChoices has tackled issues around blended case management, family based mental health services, and summer therapeutic activities programs.

CREATION OF A SEAMLESS SYSTEM OF CARE

HealthChoices has worked to bring together the behavioral health MCO, SCA, Mental Health/Intellectual Disability administrators, and providers to remove treatment barriers and create co-occurring treatment options for recipients. This results in a single, unified, data-driven system of care at the county level, and helps the county manage the quality of services systems across the board. Through county and regional HealthChoices committees, representatives from various county systems are able to participate, allowing for an optimal sharing of ideas and seamless transition for members between the different program areas. The coordination across the various systems also allows counties to find supports much quicker for those who gain and lose eligibility within Medical Assistance. The county is immediately aware of an individual losing eligibility and can immediately begin to set up the proper supports to continue necessary care.

COORDINATED, RECOVERY-ORIENTED SERVICES FOR INDIVIDUALS

By having the oversight of Health Choices funded services and base funded services at the local level, a coordinated service plan is created for individuals to meet their needs. Counties also engage with their BH MCOs in educating and monitoring providers on recovery oriented principles and practices. Administrative funds have been used to fund trainings for providers on topics including peer support services certification. These components are essential to helping individuals with behavioral health issues function as productive citizens in their day to day living.

INNOVATIVE AND COLLABORATIVE PROGRAMS

The model used in the HealthChoices program gives the county the pivotal role of setting priorities for the program and unifying service development and financial resources at the local level closest to the people served. HealthChoices has increased the ability of counties to coordinate Medical Assistance funded behavioral health services with other systems – some examples of coordination include school satellite settings providing mental health services to children and adolescents; outpatient mental health satellites located at juvenile detention centers; and community re-entry programs/centers. The reinvestment dollars provided by HealthChoices have also brought a variety of interested county human services providers to the table to come up with the best innovative programs and solutions to resolve ongoing challenges faced across all of the systems while decreasing costs and avoiding duplication.

CONTINUOUS QUALITY IMPROVEMENT

Counties have been able to more actively engage in continuous quality improvement through relationships with BH MCOs, providers and consumers. This has been done by establishing structures that promote feedback from consumers and by implementing evidence-based practices. These processes address issues that need immediate attention, including finding services and resources in the community, advocating with the provider to improve services consumers are receiving, and improving communications with the BH MCO.

SUCCESSFUL CLOSURE OF STATE HOSPITAL BEDS

HealthChoices has allowed for a full integration of resources within the counties to successfully close state hospitals, providing support for closing state hospitals across the state, allowing individuals previously institutionalized to receive the coordinated treatment among several systems through the use of reinvestment funds, base dollars, CHIPP and HealthChoices. HealthChoices has also better enabled counties to manage the high risk individuals needing individualized planning among various agencies who had previously been cared for at these facilities. There have also been enhanced opportunities to evaluate the needs of local citizens residing in a State Hospital, assess the local resource network, then design and implement specialty services that successfully treat and support individuals in the community.

INCREASED UTILIZATION OF EVIDENCED BASED PRACTICES

The ability to unify and cross systems and funding streams made possible by HealthChoices allows counties to implement new programs that have proven evidenced based outcomes, which would not be possible within the traditional categorical funding sources that do not allow flexibility. This results in better services for high-risk, specialty populations crossing various systems, and reduces placement and cost-shifting in the long run.