Behavioral Health System Transformation

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Trends in Public Behavioral Health

- States Facing "Intractable" Challenges

- Opioid Epidemic Identified by Public Officials
  - Governors and Legislatures Have Prioritized Issue
  - Congress Has Identified Issue and Funded
  - Issues with MAT Diversion (Methadone/Suboxone)

Trends in Public BH continued…

- High Profile Mental Health Related Violent Incidents– Crisis Stabilization Access
- Prevention & Wellness
  - Look at what is preventing cost savings
    - Obesity, diabetes, risk for heart disease
    - Even more expensive when combined with BH disorders
  - Focus shifting to health behavior change

Trends in Public BH continued…

- Technological Advances
- Address Provider EHR Capacity
  - Clinically Driven
  - Facilitate Integrated Care
  - Efficient Data Collection
  - Required by ACA

Why Integrated Care?

- Burden of behavioral health disorders is great.
- Behavioral and physical health issues are “interwoven”.
- Treatment Gap behavioral health disorders is large.
- Primary care in Behavioral Health settings enhance access
- Providing MH & SA services in primary care settings reduces stigma.

Why Integrated Care?

- Treating “common” behavioral health disorders in primary care settings is cost effective.
- Majority of people with behavioral health disorders treated in collaborative/integrated primary care settings have good outcomes.

Source: Collins, C., Hewson, D. L., Munger, R., Wade, T., (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund.

Barriers to Integrated Care

- BH and PH providers operate in “silos”
- Rare sharing of information
- Confidentiality Laws and Regulations
- Payment and parity issues still persist.

Source: Collins, C., Hewson, D. L., Munger, R., Wade, T., (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund.

Review of BH Managed Care Carve-outs

- Elliot D. Pollack & Co. Review for Arizona concluded after conducting a review of the "extensive research" on BH carve-out arrangements , *The evidence is dramatic and uncontested: behavioral health carve-outs have resulted in significant containment of costs while increasing access to care and the quality of care.*

Review of BH Managed Care Carve-outs

- Further, the research done by Pollack *did not uncover any studies that endorsed the 'carve-in' approach where traditional health plans would administer behavioral health services on a fee-for-service contract.*

Pennsylvania Quick Facts

- 12 million residents.
  - 20% adults will have a diagnosable mental disorder; of which over 5% will be a serious mental illness; over 9% will have a substance use disorder.
- 2.2 million projected Medicaid members (FY11-12).
- 2 urban centers (Philadelphia, Pittsburgh = 38% MA members).
- County-based system for human services.
  - Organized as 49 county joinders for mental health and drug and alcohol services.
- Office of Mental Health and Substance Abuse Services (OMHSAS) within umbrella Department of Human Services (DHS) oversees behavioral health system; DHS is single state agency for Medicaid; Department of Drug and Alcohol Programs (DDAP)is single state agency for drug and alcohol.

In the beginning…

"I love it when a plan comes together !"

HealthChoices Goals

- Increase access.
- Improve quality of services.
- Stabilize Medicaid funding.

In the beginning…

- HealthPass in Philadelphia (demonstration model).
- Voluntary Managed Care in Southeast.
  - Physical Health Managed Care Organizations subcontract for BH services.
  - "Third Leg of Profit;" money did not reach individual; huge profits.
  - Philadelphia Inquirer Expose.
- Primarily FFS in remainder of state.
  - Integrated; all FFS.
  - No care management.
  - Increased costs.
  - No coordination.
- Setting the stage for HealthChoices.
  - Ridge Administration support and implementation of Behavioral Health HealthChoices.

HealthChoices Overview

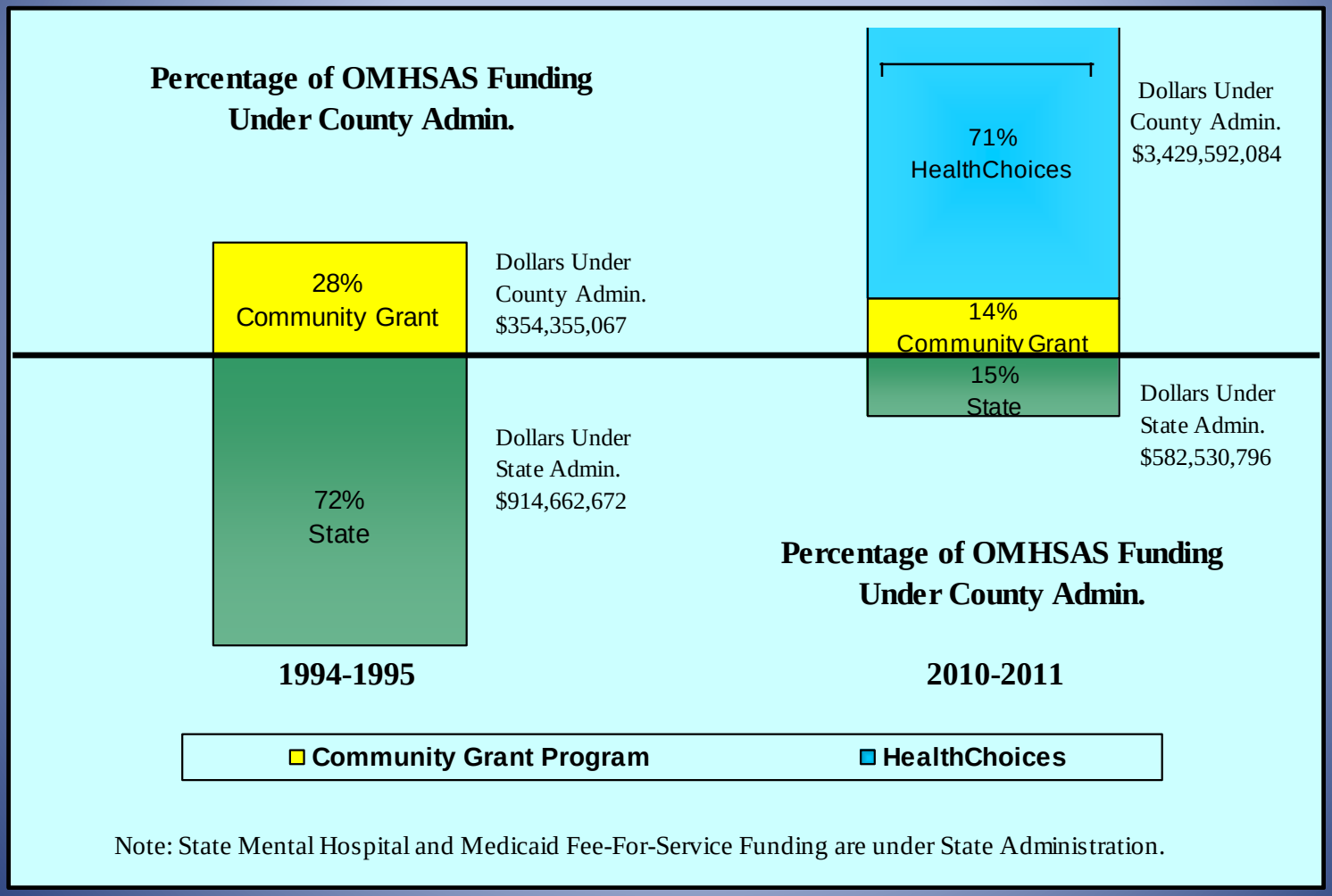
- CMS Waiver Authority: 1915 (b) Waiver, submitted every two years.
  - 25 County Waiver
    - Physical health: choice of HMOs.
    - Behavioral health: 24 contracts with counties, 1 direct contract (Greene).
  - 42 County Waiver
    - Physical health: Access Plus (PCCM); voluntary HMO.
    - Behavioral health: 19 counties; 1 direct state contract for 23 counties (Community Care).

HealthChoices Program

- As of January 1, 2010, 1.78M enrollees in HealthChoices; 2.2M projected in MA overall for FY11-12.
- Projected enrollment in HealthChoices for FY10-11 is 1.88M.
- FY10-11 funding projected to be $2.839B in the Southeast, Southwest, Lehigh/Capital, Northeast zone, 23-county expansion zone, and 15-county expansion zone:
  - Legacy zones (SE, SW, L/C) $ 2.163B
  - Expansion zones (NE, SO, CO) $ 676M
  - Mental health portion* $ 2.507B
  - Substance abuse portion* $ 332M
- Reinvestment (savings) generated since 1997: $ 446M (3.1%).

* Includes administrative costs.

Movement of Funding from State to County Administration



Note: State Mental Hospital and Medicaid Fee-For-Service Funding are under State Administration.

HealthChoices Program: Key Features

- County Right of First Opportunity: Sole Source Contract.
  - County options for acceptance of risk.
- Provider choice for in-plan services:
  - All MA Providers in initial year.
  - Choice of two providers each level of care within access standards; reviewed annually.
- Includes all state and federal eligibility categories of Medicaid.
- Broad behavioral mandate; includes mental health, drug and alcohol, PDD autism, Behavioral Health Rehabilitation Services (BHRS) for mental retardation.
- Includes special populations, children and youth, and persons with intellectual disabilities.

HealthChoices Program: Key Features

- Pharmacy Benefits (with the exception of Methadone) paid for by physical health or FFS.
- State Plan Services, cost-effective alternatives and supplemental services available.
- Consumer/Family Satisfaction Team (C/FST) in every contract.
- Reinvestment of savings at the local level; must be committed to behavioral health and targeted to Medicaid population.
- Performance measurement system.

HealthChoices Today

- Program is statewide; 10 years to fully implement.
- BH program began in 1997; phased in through 2007.
  - 43 counties (joinders/multi-counties) accepted the right of first opportunity; mixture of ASO and county risk-sharing arrangements.
  - 23 counties (rural): state contract; 1 county (southwest zone): state contract.
- Five current contractors/subcontractors: Community Care Behavioral Health Organization; Magellan Behavioral Health; Value Behavioral Health of Pennsylvania (VBH); Community Behavioral Healthcare Network of Pennsylvania (CBHNP); and Community Behavioral Health (Philadelphia).
- Unified systems strategy to support programs across all funding streams, including closure of state hospitals, and children in dependency, delinquency system.

Pennsylvania Behavioral Health HealthChoices Program

- Managed program costs below anticipated fee-for-service trend; administrative costs are low.
  - ***Four billion dollars in savings* ($4,000,000,000).**
- Continues to serve more people and has maintained a focus on those with the most need.
  - ***Access exceeds national benchmarks for persons with serious mental illness.***
- Continues to provide a wider array of services in less restrictive settings.
  - ***Increased drug and alcohol provider network by over 500 programs.***
- Reinvestment opportunities have sparked innovative practices and cost effective alternatives to current practices.
  - ***Less restrictive alternative services increased by 400%.***

Pennsylvania Behavioral Health HealthChoices Program

- ***Quality Standards have improved.***
- Design provides opportunities for innovative physical health and behavioral health initiatives.
  - ***Rethinking Care projects in Pennsylvania has demonstrated good outcomes and savings.***
- Unified systems and funding; maximized fiscal resources at state and local level to support major initiatives include closing of state facilities; enhanced access for high need dependent children**.**
  - ***Increased access to evidenced-based practices for children, including FST and MST.***
  - ***Closed three state hospitals.***

Improving Access

- Increased the number of people served.
- Maintained commitment to serving persons with serious mental illness.
- Provider networks expanded; able to access beyond county/state borders.
- Drug and alcohol services increase as program matures.
- Responsive cost effective alternative services (supplemental) developed.

Increased Access to Drug and Alcohol Services

- Increased access to drug and alcohol services by enrolling over 500 programs statewide.
- Increased access to non-hospital drug and alcohol detox, rehabilitation, and half-way house services as cost-effective alternative services; previously state-only funds.
- Developed more robust service array, including enhanced co-occurring capable services.

Improving Quality

- In PA, role of county government has been critical to the success of the program.
- C/FSTs feedback increasingly influencing local systems.
- Extensive QM program; identify barriers and implement performance improvement.
- Innovative program development has occurred.
- Performance Base Contracting project report allows statewide comparisons.

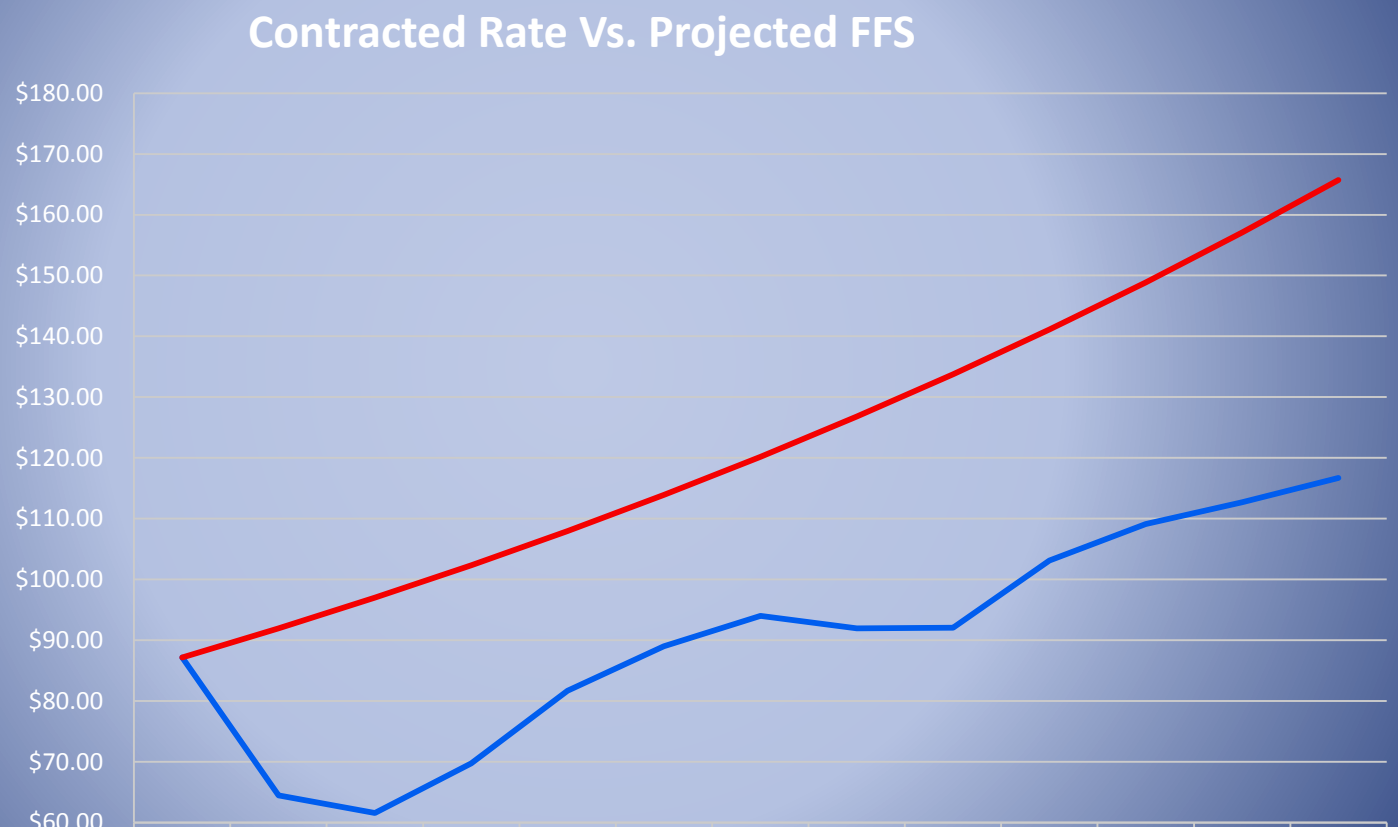
Stabilizing Medicaid Funding

- HealthChoices has managed program costs below anticipated fee-for-service trend.
- HealthChoices continues to serve more people.
- HealthChoices continues to provide a wider array of services in less restrictive settings.
- Reinvestment opportunities have stabilized as programs and initiatives mature.
- Unified systems/funding; maximized fiscal resources at state and local level.

Financial Management

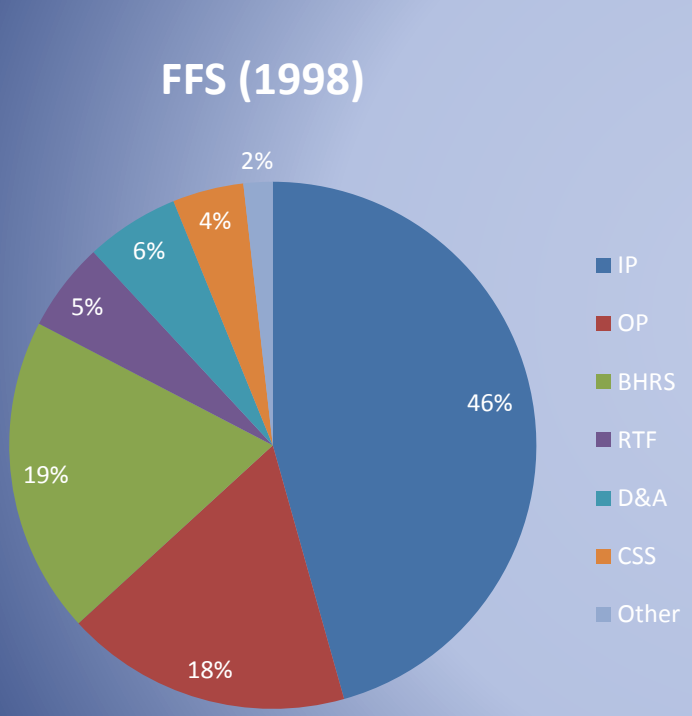
- Rate Setting
  - Methodology updated as program has matured.
  - Incorporated risk-sharing arrangements in new zones to increase financial predictability.
  - Moved from FFS data to MCO encounter data to reflect program's managed care experience.
    - Encounter data allows for detailed analysis required by initiatives such as provider profiling, supplemental services, and program dashboard.
  - Explicit profit/reinvestment component is not built into the rates, rather profit/reinvestment is gained via efficient care management or other program efficiencies.

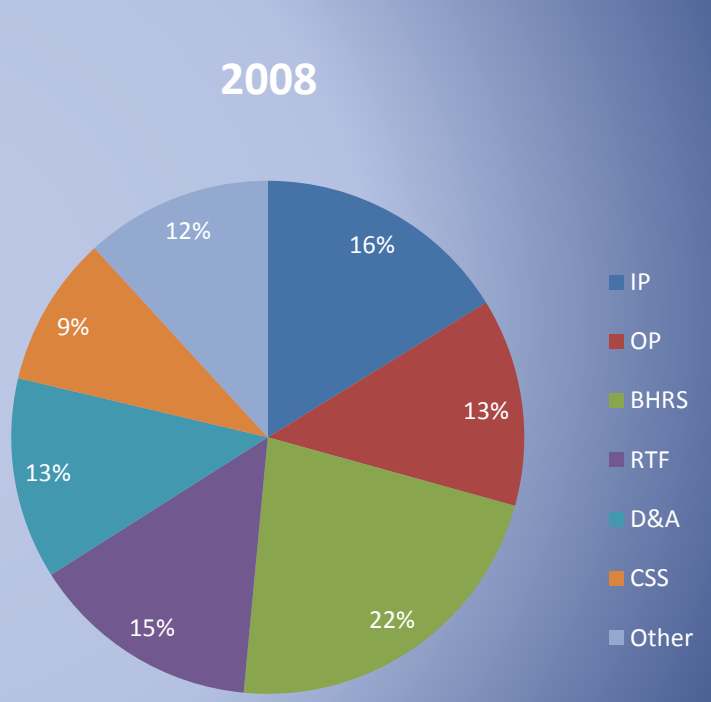
HealthChoices Savings



	1996	1998	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Medical Contracted Rate	$87.16	$64.49	$61.58	$69.72	$81.66	$89.01	$94.03	$91.97	$92.04	$103.13	$109.10	$112.70	$116.71
Projected FFS	$87.16	$91.95	$97.01	$102.34	$107.97	$113.91	$120.18	$126.79	$133.76	$141.12	$148.88	$157.07	$165.70

Systems Redesign





Integration??

As we consider how to realize the integration of behavioral health services with general healthcare, I think we need to be careful not to rush to integrated care without carefully considering what we want to gain and clearly identifying what we do not want to lose.

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What are the facts?

- People with behavioral health conditions are at higher risk for physical illness and disability, and the cost of medical care for them is, on average, much higher than the cost of medical care for people without behavioral health conditions (United Hospital Fund in New York City report).
- Medicaid recipients with mental health conditions are 30-60% more likely to have hypertension, heart disease, pulmonary disorders, diabetes, and dementia.
- People with substance abuse conditions are 50-300% more likely to have heart disease, pulmonary disorders, and HIV/AIDs.

Physical /Behavioral Health

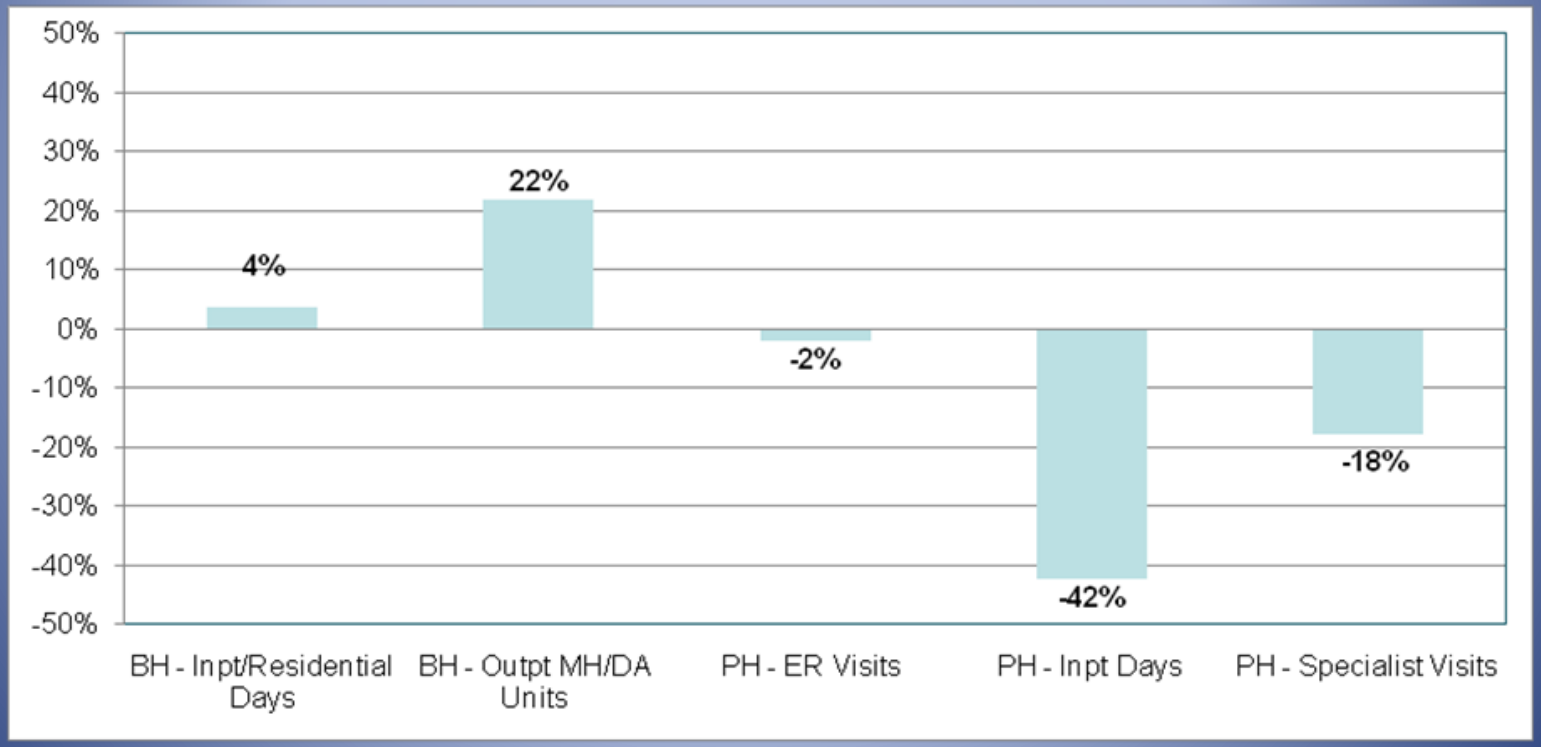
- Behavioral health is a part of overall health; good health outcomes are important to an individual's recovery.
- Integration of good health habits, prevention activities, and specific physical health interventions are best achieved through local collaborations and navigator systems.
- Good health outcomes can be achieved within the existing behavioral health system design.

Physical /Behavioral Health

- Projects supporting integration of services and supports for individuals with physical health (medical) and behavioral health needs happening across the state in urban, rural, and suburban settings.
- Co-locations; collaborations; shared staff models; health home development; shared health records.
- PA collaboration with the Center for Health Care Strategies.

HealthChoices Health Connections Pilot: Health Costs Offsets

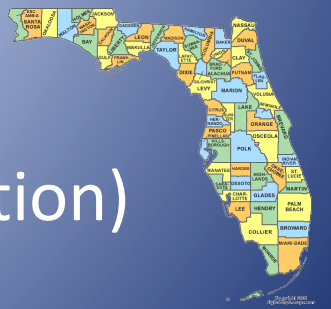
Behavioral Health/Physical Health Percent Change in Utilization Post Consent



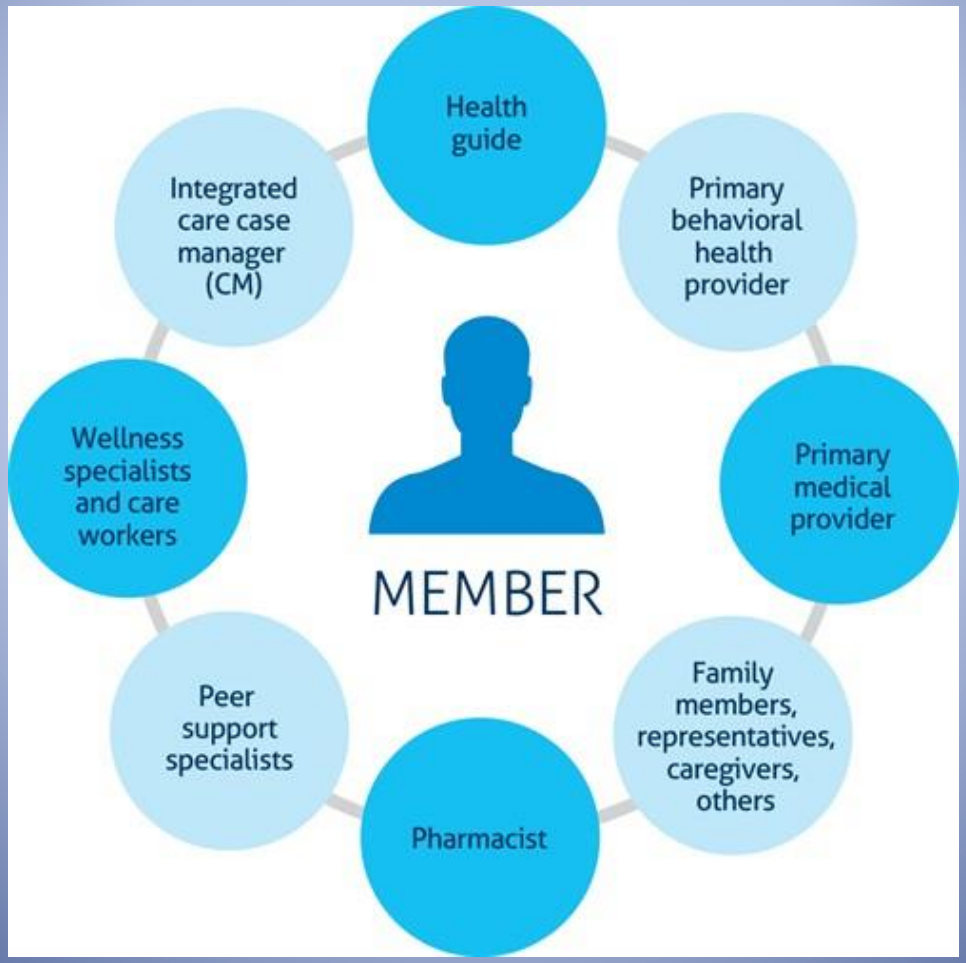
Source: Data from Bucks, Delaware and Montgomery Counties in Pennsylvania

Florida--Magellan Complete Care

- Long experience managing Medicaid BH services in FL but MCC is 2 years old
- Specialty health plan focusing on SMI
- Integrates management of behavioral and physical health services
- Collaborative model—partnerships with law enforcement, justice system, emergency departments, & other community partners
- 40 counties in FL (2/3 counties; 90% population)



MCC Model of Care



What does this mean for Alaska? DBH Vision for BH Reform

- Streamlining
- Utilization Control
- Grant Reformation
- Medicaid Redesign

How to Achieve the Vision?

- Look at models from other States—MCO, ASO, ACO, Fee-for-Service, PCCM, PIHP, PAHP, health homes, etc.
- Make policy decisions (e.g., populations, system management, geographic area, benefit package, risk arrangements)
- Develop/improve capacity—at DBH and provider levels
- Implement the systems changes

Assessing Organizational Readiness

- Leadership
- Capacity for Change
- Access, Services and Outcomes
- Business, IT, and Performance
- Clinical Infrastructure, CQI, and Sustainability
- At the State level, most important is Contract Management (role of state government)

What States have learned about Contract Management

- Identify people with SMI and Kids with SED
  - Mine the data in states
  - Require plans to identify people with SMI & Kids with SED
- Implement ways to incent enrollment of people with SMI and Kids with SED
  - Higher rates for people with more complex and/or chronic conditions
  - Mitigation of risk approaches

Contract Management continued

  - Require acceptance in a plan regardless of severity of conditions
- Include the comprehensive array of services needed for People with SMI and SED
  - Recovery oriented services psycho social rehab (psycho social necessity)
- Linkage to: prevention wellness, peer supports,

BH Managed Care Contract Standards

- Incentives to avoid cost shifting to other systems
- Consumer Choice & Protection
- Assertive outreach and access standards
- Network and providers should include those with demonstrated expertise with people with SMI and kids with SED (CMHC's)

Contract Standards continued

- Clear standards for treatment planning and coordination consumer driven
- Integrated BH/PH care standards
- Consumer involvement
- Use of Peers
- Reinvestment of cost savings as an expectation

Contract Standards continued

- Performance measures
  - Access (timeliness, geography, MH, SU & PC)
  - Service utilization (in lieu of ER, IP, more community based)
  - Quality (readmission rates, timely follow up, level of independent living, school participation)
  - Physical health metrics (hbp, cholesterol, diabetes, med compliance)
  - BH metrics

QUESTIONS?

THANK YOU!

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