Webinar Participants

• Joan L. Erney (Panelist)
  CEO, Community Behavioral Health

• Marvin Levine (Panelist)
  SCA, Philadelphia County

• Victor Kogler (Project Director)
  Vice President, CA Institute for Behavioral Health Solutions

• Elizabeth Stanley-Salazar (Moderator)
  Project Manager, CA Institute for Behavioral Health Solutions
Designing a Unified System of Care

Joan L. Erney, CEO, Community Behavioral Health
Marvin Levine, SCA, Philadelphia County
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Philadelphia’s Profile

- Population: 1,547,607 (5th Largest City in the USA)
  - 42% African American
  - 13% Hispanic
  - 8% Asian or other

- 51% of individuals make less than $35,000 per year
  - 28% (3 of 10) of all Philadelphians are below the poverty line
  - In the first half of 2012, Medicare and Medicaid paid for 72.8% of all city residents treated in hospitals
  - 15% of adults and 5% of children were uninsured

- 2nd highest unemployment rate in US in 2012 - Detroit has higher unemployment

- Highest homicide rate among 10 largest cities

- High School graduation rate was 64% in 2012, rising from 52% in 2005
Philadelphia Behavioral Health System

- Single payer system operated by the City
- $1b Service system for children, adults & families
- Substance Abuse and Mental Health, Behavioral Health
- Range of services from hospitals to outpatient programs
- Recovery and resilience system transformation
CBH Introduction

- Philadelphia created Community Behavioral health (CBH) in 1997 to provide administrative services for the HealthChoices Behavioral Health Program.
- CBH is a 501 (C)(3) Non-Profit with a majority County Board. One external advocate also sits on the Board of Directors.
- CBH sits within the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) which falls under the Deputy Managing Director. The City of Philadelphia assumes full risk for the HealthChoices behavioral health, maintaining reserves and risk protections consistent with commercial insurers.
- As of 2015, CBH membership reached 577,000 members, holding contracts with over 200 providers, and providing services to over 113,000 members.
- As an ASO, CBH manages the full spectrum of behavioral services
- Consistently, CBH has low administrative expenses and retains no excess revenue, thereby allowing all savings to be available for reinvestment.
HealthChoices Program Goals

- To improve access to health care services for Medical Assistance recipients
- To improve the quality of health care available to Medical Assistance recipients
- To stabilize Pennsylvania’s Medical Assistance spending
County Right of First Opportunity

- In Pennsylvania County government has legislative authority and programmatic and fiscal responsibility for mental health and substance use delivery systems
- County leadership includes a Mental Health/Intellectual Disability Administrator and a Single County Authority (which could be a position or separate not for profit entity)
- County government is also responsible for an array of other human services, including child welfare; housing and homelessness and court systems
County Right of First Opportunity

- In Pennsylvania Single County Authorities have responsibility to administer
  - Federal Substance Use Block Grant Funds (SAMHSA, SSBG)
  - State Base funding
  - Act 152 (State Medicaid funds to support non hospital rehab)
  - BHSI (funding stream for uninsured)

- SCA’s also have authority for initial intake/assessment and to administer PCPC (PA Client Placement Criteria) used to make level of care/medical necessity decisions (in lieu of ASAM)
County Right of First Opportunity

- In Pennsylvania HealthChoices Behavioral Health Program was phased in over 10 years. County Government offered right of first opportunity and could contract with the Commonwealth using several models:
  - Develop own BHO (Behavioral Health Organization)
  - Contract with ASO (Administrative Services Organization)
  - Contract with MCO (Managed Care Organization) and download majority of risk
- County government remains at risk for any of these options
- Reinvestment becomes available limited to usage to behavioral health
HEALTHCHOICES ZONES

- **SOUTHEAST**: Implemented Feb. 1997
- **SOUTHWEST**: Implemented Jan. 1999
- **LEHIGH/CAPITAL**: Implemented Oct. 2001
- **NORTHEAST**: BH Implementation July 1, 2006
- **NORTH/CENTRAL**: BH Implementation January 1, 2007
- **NORTH CENTRAL**: BH Implementation July 1, 2007
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.
• All State and Federal Eligibility Categories of Medicaid included in HealthChoices.
• Broad Behavioral Mandate; includes mental health, drug and alcohol, PDD autism, Behavioral Health Rehabilitation services for children with intellectual disabilities.
• Special populations included; children and youth; 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 Teams (C/FSTs) in every contract.
- Reinvestment of savings at the local level; must be committed to behavioral health and targeted to Medicaid population.
- Performance Measurement System.
Substance Use Services: In Plan/Supplemental

- **In Plan (State Plan and Act 152)**
  - Inpatient drug and alcohol detoxification
  - Non Hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence (Act 152)
  - Outpatient D&A services, including Methadone Maintenance
  - Laboratory and diagnostic studies
  - Crisis Intervention (telephone, mobile with in-home capability)

- **Supplemental SA Services**
  - Substance use/Co-occurring partial hospitalization services
  - Recovery Specialists
  - SA Case Management
  - Intensive Outpatient for SA (IOP)

- **FIR**
  - *Forensic Intensive Recovery (special note)*
HealthChoices Program: Financial Overview

• Capitation: Per Member Per Month (PMPM), at risk for overages, able to keep up to 3% (savings) for reinvestment

• Capitation payments are required to be actuarially sound, based on an “efficient” and “well operated” managed care organization

• Providers predominantly paid on FFS basis, Alternative Payment Arrangements (APA) must be approved by the state and shown to be cost effective
Poll #1

What do you believe will be your greatest challenge moving into the managed care environment? (check one)

- Making services accessible to members
- Integrating with existing systems of care
- Managing implementation with existing resources
Questions?

Submit your questions using the questions box on the control panel
Managed Care Implementation: Considerations at Start-Up

• Roles and Responsibilities of Parties
  • State and Federal Waiver/ Program Obligations
  • County Authority and model/contract for managed care functions

• Readiness Review
  • Every part of the system should test itself to confirm readiness
  • Structures in place to resolve issues

• Early Warning System
  • Identify key indicators related to system performance
    – Examples include increases in ER visits; inpatient admissions, commitments,
County Functions: Considerations at start-up

Establish Vision and Guiding Principles and Expected Outcomes

- Understand Program Design and 1115 waiver requirements/opportunities
  - State plan services
  - Supplemental services
- Confirm if state or local authorities are developing Standards of Practice- is there local latitude or state directed
- Develop Readiness Review Instrument/ Early Warning System
- Develop Public educational materials
- Develop Initial /ongoing monitoring process
- Establish and implement reporting mechanics
- Establish and implement financial agreements/ audit plan
- Establish savings plan/goals
County Functions: Considerations at start-up

- How will program integrate/coordinate into existing infrastructure at local level
- Letters of Agreement with physical health plans, school districts, other human services
- Development and monitoring of Provider Network - Role of County/ MCO
- Role of County in financial management, including provider rate setting - implications for non MA residents
- What are the capabilities of county staff to monitor - county options: 501C3 between multiple counties, county civil service staff; access to quality management, fiscal competency and physicians
MCO Functions

- Delineate what role the county assumes/what functions the ASO/MCO will cover
- How will administrative dollars be allocated between county/mco?
- 24-7 capability—does the county have an emergency service—what will the linkage be
- Information & Referral (similarly, can you tie in I&R into existing systems)
- Community Outreach and Engagement
- Utilization Management
- Network Management including provider contracting and monitoring
- Quality Management, including Complaints, and Grievances, Incident Management
- Data Management and Reporting
- Claims Payment
- Financial Management
- Linkages/agreements with other human services and health systems
Role of Individuals, Advocates and Families

- Participate at every level (*nothing about us without us*)
- Be part of readiness review
- Host /advocate members to educate about program
- Understand grievance/appeal processes
- Be part of ongoing monitoring; state advisory committee
  - Consumer /Family Satisfaction Team
- Trouble shoot
HealthChoices Program
Philadelphia: Lessons Learned

• There are always bumps
• Communication and quick deployment keys to success
• Members/individuals with lived experience need assurance and multiple avenues to express concerns
• Public Sector Providers need significant support based on experience with managed care
• KEEP TO THE BASICS
Questions?

Submit your questions using the questions box on the control panel
HealthChoices Program
Philadelphia: The Upside

• Tremendous impact in our community: met the goals of increased access, enhancement of quality and financial stabilization/savings

• Increased access thru serving 48,000 in year one to serving over 113,000 in 2015. Access was also increased thru expansion of our provider network with innovation program models and service access to more individuals.

• Created performance and quality monitoring system that is beginning to show benefits; also had resources to invest into evidence based practices

• Stabilized Medicaid funding; reinvestment opportunities thru savings into the community to support program priorities for the city
Key Initiatives

- Evidenced Based Practices
- Physical Health-Behavioral Health Collaboration
- Children’s Transformation
  - School Based Services
  - DHS Child Welfare Collaboration
  - SAMHSA System of Care
  - PACTS - Trauma Informed Care
- Permanent Supportive Housing
Provider Profiles and Pay-for-Performance

- Provider profiling is required by the HealthChoices contract
- Results are used to determine Pay-for-Performance awards
- Every eligible provider receives a report of their performance, regardless of whether they receive an award
- Awards are based on a percentage of provider dollars determined by CBH and DBH based on budgetary considerations, multiplied by the provider’s weighted score
Residential Rehabilitation: Continuity of Care

Residential Rehabilitation - Women with Children Providers: Continuity of Care: 30-Day Follow-up Rate

- 2011: 58.75%
- 2012: 64.03%
- 2013: 72.54%
Journey of Hope: Continuity of Care

Journey of Hope: Continuity of Care:
14 Day Follow-Up Rate for Successful Completions

- 2011: 54.9%
- 2012: 63.0%
- 2013: 67.1%
Special Needs Team: In 2014 the Special Needs Team served on average 175 or more unique individuals each month with a range of 135 to 220 monthly

Community Based Care Management Team with Health Partners (Physical Health Plan)

Integrated P4P Program (Health Choices requirement in January 2016)

Behavioral Consultant Model in FQHC and FQHC look alikes

Smoke Free contract requirements in psychiatric inpatient- and now in non hospital rehabilitation facilities collaboration with Phila Dept of Public Health
Permanent Support Housing Initiative

- Partnership between CBH’s Community Supports Services (CSS) and Housing Clearinghouse began on January 23, 2012.
- Targeted population for 18-month pilot included individuals from 3 largest residential providers.
- CSS & Clearinghouse also receive referrals from:
  - Programs serving chronically homeless individuals (Safe Haven and Journey of Hope)
  - McKinney (i.e. Project-based and scattered sites)
  - Emergency Housing (Shelter)
- Providers’ participation in pilot requires them to offer:
  - Certified Peer Specialists (CPS)
  - Mobile Psychiatric Rehabilitation Services (MPRS)
  - Case Management (Mental Health and SA)
- To date, 1100 of individuals have been housed in the community with supports.
Overview of the PA Long-Term Financial Performance

- The estimated savings for the Pennsylvania Medicaid Behavioral Health Choices program is $9 Billion between 1997 and 2013 in the Southeast, Southwest and Lehigh/Capital (legacy) regions.
- Pennsylvania Medicaid Behavioral Health Choices program, conservatively, saved $4 Billion between 1997 and 2008 in the legacy regions.
- The BH carve-out model supported local integrated human service systems based upon local county authorities building necessary partnerships.
- During this time period there was demonstrated improvement on key quality performance measures and increased access to behavioral health services, including for key vulnerable sub-populations.
- A review of performance between 2009 and 2013 using Community Care Behavioral Health contracted rates as a proxy for Health Choices experience indicated an estimated additional $5 Billion of savings compared to projected Fee-for-Service (FFS) expenditures.
- The difference in the estimated national Medicaid behavioral health trend rate and Health Choices BH trend between 2008 and 2013 is 4.7% annually.
- Medical spending averages over 90% inclusive of reinvestment spending.
“Finding Home”