

# I. HealthChoices Behavioral Health Program

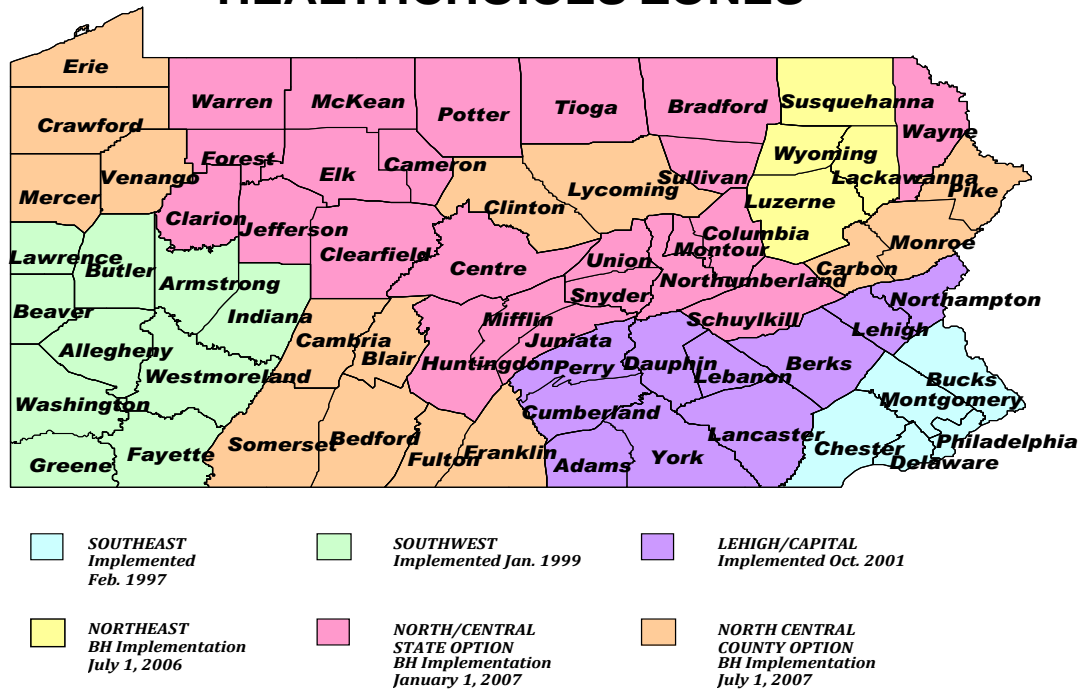
## Background

The HealthChoices Behavioral Health (HC-BH) program, first implemented in southeast Pennsylvania in 1997, makes mental health and drug and alcohol services available to over 2 million Pennsylvanians. The three goals of the program are to assure greater access to services and improve quality while managing costs. A decade later – in 2007 – OMHSAS achieved its mission of creating a unified BH system in all 67 counties and ensuring access to recovery-oriented services and supports for individuals served by the program.

## Snapshot – HealthChoices

- 1915(b) Federal Waiver - HealthChoices, Pennsylvania’s behavioral health Medicaid managed care program is available in all 67 counties
- Started in 1997 in SE zone; statewide implementation achieved in 2007
- 2.1M Medical Assistance eligible Pennsylvanians enrolled
- 3.1% average annual savings reinvested in unmet and under-met needs (2010)

## HEALTHCHOICES ZONES



The success of the HC-BH program was built in partnership with county government, which is legally responsible for providing and managing mental health services under the MH Act of 1966. County government is given the “right of first opportunity” to bid on the HC-BH program to manage risk-based contracts. HC-BH unifies service development and financial resources at the local level closest to the people served. Medicaid eligible individuals enrolled in the program are automatically enrolled in the BH program in the county of their residence. A risk-based contract allows flexibility to make decisions that meet the unique needs of the county and, if savings are created, the county must reinvest the money in approved programs and supports that meet the needs of people served. The HC-BH model has lived up to its mission and fostered counties’ success in controlling the growth of Medicaid spending while increasing access and improving quality.

### Increasing Access

The HC-BH program ensures choice, flexibility, and cost-effective alternative services. For example:

- Standards require a choice of two providers for each in-plan service (e.g., outpatient services) and access within 30 minutes for urban areas and 60 minutes for rural areas.
- HC-BH includes services such as drug and alcohol non-hospital residential rehabilitation services that are not available in the Medicaid fee-for-service program.
- People enrolled in HC-BH can go to the provider closest to their home, even if it is in a different county.
- Behavioral Health Managed Care Organizations (BH-MCOs) have the flexibility to contract with individual practitioners and to develop “supplemental services”, which are cost-effective alternatives to in-plan services (i.e., psychiatric rehabilitation services).

Over its 12 year history, approximately \$446M (3.1%) of the HC-BH dollars have been reinvested into the expansion of service options in the community. In planning for reinvestment funds, counties analyze trends and consult with local stakeholders to determine reinvestment priorities. Priorities have targeted unmet or under-met needs and focused interventions to increase quality outcomes, such as reduction of psychiatric inpatient admissions. Reinvestment has been used for start-up funds to develop services targeted for special populations, including persons with autism, Latinos, intellectually disabled individuals, and persons who are deaf

or hard of hearing, among others. Start-up funds to expand substance abuse services resulted in increased access as the program has matured. Consumer-run services such as warm-lines, Certified Peer Specialists, and peer mentors have been created with reinvestment funds.

Reinvestment funds can be used to fund non-medical services and supports such as supportive housing. In partnership with the Pennsylvania Housing Finance Agency (PHFA), reinvestment funds were used to leverage safe, affordable housing options for people with a serious mental illness. Non-medical services have included development of mental health forensic sequential intercept models for people with a serious mental illness involved in the criminal justice system.

### **Improving Quality**

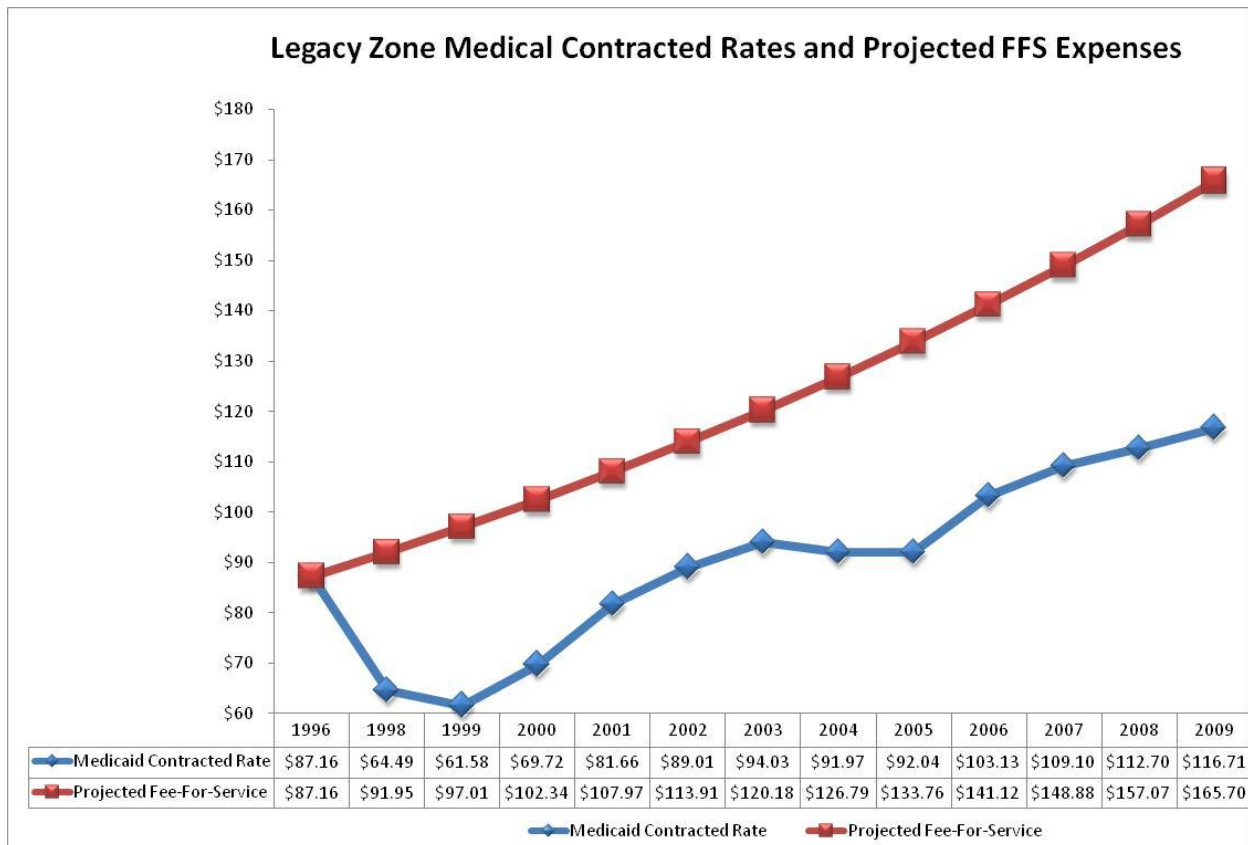
HC-BH contracts are built on recovery and resiliency principals. Consumers and families serve on the evaluation committee that selects the BH-MCO and are members of the Quality Management Committee established under each contract to oversee the program. Counties and BH-MCOs are required to establish Consumer/Family Satisfaction Teams (C/FSTs) that conduct face-to-face surveys to determine if the program is meeting the needs of people served.

The HC-BH Performance report, published annually, presents the results of C/FST survey questions and 29 quality indicators. The program is reviewed annually by an external quality management organization which submits a report to the Center for Medicare and Medicaid Services (CMS) regarding the effectiveness of the state's oversight. HC-BH contractors are required to develop performance improvement plans and have recently participated in a Pay-For-Performance initiative.

The OMHSAS Advisory Council and the DPW Medical Assistance Advisory Committee (MAAC) receive regular updates about the HC-BH program and provide feedback from stakeholders about how the program is working. Each contract has an OMHSAS contract monitoring team in the regional field office.

### **Controlling Costs**

The HealthChoices Behavioral Health program has been able to decrease the rate of medical cost increases over projected FFS costs (see chart below).



Some of the savings have been achieved by ensuring that services are delivered in the least restrictive setting which can meet the needs of the consumer. The flexibility and accountability of the program have reduced the use of intensive and expensive services and increased the use of community-based services. For example, in the HC Southeast Zone in 1996, 38% of all fee-for-service dollars were spent on inpatient hospitalization and 4.4% on community support services (CSS). In HealthChoices in 2008, 16.2% was spent on inpatient hospitalization and 9.5% on CSS. The HC-BH contractors may provide supplemental, cost-effective alternative services that are not in the Medicaid State Plan. One example is the use of Assertive Community Treatment teams that reduce the use of higher cost inpatient psychiatric stays. Another example is the use of non-hospital based drug and alcohol services that reduce the use of higher cost inpatient services. The types of cost effective alternative services and expenditures are detailed by OMHSAS and its actuaries in the CMS actuarial certification letter.

### **Program Accountability**

OMHSAS, through the HealthChoices Behavioral Health Program, has systematically increased accountability for the management of behavioral

health services and financial resources throughout Pennsylvania by instituting the requirements described below.

- **Financial Reporting Requirements:** The counties and their BH-MCO partners (contractors) submit monthly, quarterly, and annual financial reports to ensure that solvency, financial, and reporting requirements are met. The OMHSAS financial team reviews the reports and conducts quarterly meetings with plans to determine if programmatic or policy changes are required.

In 1998, contractors submitted ASCII files which OMHSAS entered into a database. Audit Adjustments were data entered manually. In 2004, a new COGNOS database was developed where reports are uploaded by the contractors directly into the database via the internet. The data is imported into a multidimensional data base known as a “cube” that allows extraction and manipulation of the data based on specific criteria and allows for detailed analysis as needed. Contractors also submit audit/prior year adjustments using the new database. Two additional cubes were developed that include detailed information on the persons served and the services rendered (Person Level Encounter data). These cubes offer the ability to analyze specific eligibility and levels of service by person.

- **Audit Requirement:** Each HC-BH contract is required to have an annual audit that attests to the accuracy of the information contained in its financial reports. In addition, within the audit, management must attest to compliance factors and management assertions. Typically, there are very few audit findings.
- **Solvency Standards:** Three solvency standards are required for each HC-BH contractor:
  - Risk Protection for High Cost Cases (Reinsurance)
  - Insolvency Protection (Secondary Liability) – A minimum of 60 days’ worth of paid claims in a restricted fund, via a letter of credit, performance bond, or parental guaranty. These funds are attached by the Department only in the event of insolvency and must be maintained at full value at all times.
  - Equity Requirement – A minimum of 5% of annual net HealthChoices capitation, in conjunction with any equity requirements by the Pennsylvania Insurance Department, where applicable.

- An annual approval of each Contractor's plan to meet the standards is performed by OMHSAS. The plan is monitored on a monthly and quarterly basis to ensure continued compliance. To date, all of the contractors have met or exceeded these requirements, with very few corrective action plans required.
- Claims Processing Timeliness: The contractors are required to adjudicate 90% of clean claims within 30 days, 100% of clean claims within 45 days, and 100% of claims must be adjudicated within 90 days. Each County/BH-MCO submits a quarterly report that is monitored by OMHSAS. Contractors have met or exceeded these requirements with very few exceptions.
- Waiver Cost-Effectiveness Requirement: The Department operates the HealthChoices behavioral health program under 1915(b) waiver authority granted by CMS for a two-year period. CMS reviews the technical and cost-effectiveness waiver components and resolves any concerns prior to approval or implementation. OMHSAS and the Office of Medical Assistance Programs complete the cost effectiveness test quarterly and address areas of concern. The Department has met the cost-effectiveness requirements of all waiver submissions since 1997.
- Use of Actuaries in Rate Setting: CMS requires that capitation rates (fees paid to the contractors on a per member per month basis) be actuarially sound. DPW and CMS receive a certification from DPW's actuaries that assures that the capitation rates were developed using actuarial standards and that the rate setting meets the CMS requirements. CMS has approved all rate submission packages since the inception of the HC-BH program.
- Program Evaluation Performance Summary (PEPS) – The PEPS is a review of contractual and program standards of the HC-BH program conducted over a three-year cycle. HealthChoices monitoring teams in the regional field offices issue plans of corrective action when warranted. OMHSAS reports are submitted to an external quality review organization (EQRO), as required by the waiver. The EQRO reports to CMS annually on the effectiveness of the state's oversight.

## Progress

- Statewide implementation of HC was achieved by 2007.
- Data shows that HC-BH is successful in offering people with serious mental illness non-institutional services. In 2008, twice as many people with a serious mental illness received community-based services compared to the national average.
- In 2009, consumer satisfaction was 81.5 % to 96% on the top ten measures of the Recovery Oriented Systems Indicators (ROSI).
- Access to providers increased in comparison to the Medicaid fee-for-service program.
- Overall quality improved, shifting the delivery from a medical model to recovery oriented services.
- HealthChoices controlled the rate of growth of Medicaid program compared to fee-for-service anticipated trends.
- Administrative fees have been reduced over the years.
- Reinvestment opportunities have stabilized as programs and initiatives mature.
- HC-BH increased access to drug and alcohol abuse (D&A) services as the program matured.
- BH-MCOs consistently meet equity and insolvency protection requirements.
- County government achieved a unified program financing strategy managing all state and federal funds.
- OMHSAS has received CMS waiver approval at each two-year renewal submission.

## **Resources:**

- HC Program Standards and Requirement Document – 2009  
[http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s\\_002381.pdf](http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002381.pdf)
- HealthChoices Overview – listing of county contracts, oversight entity, BH-MCO  
([http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s\\_002108.pdf](http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002108.pdf))
- HealthChoices Performance Report – 2009  
([http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s\\_002762.pdf](http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002762.pdf))