In Support of the HealthChoices Behavioral Health Carve-Out

December 2018

Over the last several months, there has been discussion concerning continuation of the long-standing HealthChoices behavioral health "carve-out" program in Pennsylvania. In addition to some open administration dialogue over the need for improved physical health (PH) and behavioral health (BH) integration, there is now specific legislation being proposed which would end this program in favor of a "carve-in" model.

RCPA, as the largest behavioral health trade association in Pennsylvania representing over 300 members across all areas of health and human services, **stands in support of the continuation of the present county-based carve-out program**.

We come to this position based on several considerations, including:

- The program is stable and has been successful;
- Access to care has greatly increased;
- Consumer choice has been maintained and improved upon;
- The addition and expansion of needed services, supplemental services, and use of reinvestment dollars have been hallmarks of the provider service delivery design;
- Support for community provider innovation, especially for special populations such as those entering the community from state institutions;
- The infrastructure to manage the program is in place;
- Reporting structures and quality oversight are in place;
- There is significant stakeholder input to the program; and
- The program has demonstrated cost savings against the trend since its implementation over 20 years ago.

So why are people exploring ending this successful model in place of an alternative carve-in approach? Some of the answer is in that over the last 20 years, many things in health care have changed. There is more focus now on a "whole-person" approach and on the integration of physical and behavioral health care. Similarly, there is the belief that there will be more innovation and a more complete move to value-based purchasing models if the BH and PH funds are intermingled.

To address these and other concerns there needs to be an objective and careful review of each assumption:

- **Assumption One:** The carve-in model promotes better PH/BH integration and a whole-person approach.

  Response: Neither RCPA nor our colleagues have uncovered objective, supportive data to justify this change. Is there data and experience nationally that supports this assertion? Or is it a theoretical argument that has some face validity but no real numbers behind it? Couldn't the current carve-out model adequately address this concern?

- **Assumption Two:** The carve-in model promotes better integration through the co-mingling of PH/BH dollars.

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Response: Again, is there data to support this contention? There are certainly ways in which the behavioral health managed care organizations (BH-MCOs) and the physical health managed care organizations (PH-MCOs), with administration support, could address this issue as well.

- **Assumption Three:** There will be saved administrative costs through the carve-in.

  Response: This, too, would need to be quantified. Clearly, there will be increased administrative costs to PH-MCOs to manage behavioral health care. And the cost of a significant system change to a 20+-year-old stable program (i.e., the carve-out) needs to be factored in.

Further, many of the PH-MCOs – even when the behavioral health is carved-in through commercial insurance or other states' programs – turn around and carve-out behavioral health to BH-MCOs anyway. So, under that scenario, would the perceived advantages really be achieved through the elimination of the current carve-out model? And when it falls under a physical health plan, would behavioral health get the same attention as it does in a carve-out model? Without tight state controls, could there be a shift of funds to physical health?

There are pros and cons to all payment and managed care program models. If Pennsylvania was designing a brand-new program today, perhaps HealthChoices would have a different design in place, or certainly a model tweaked from how it exists today.

But we live in the reality that we have a successful, stable behavioral health carve-out program in place in PA. Therefore, the following recommendations are put forth:

- The continued development of <u>integrated PH/BH programs</u> within the carve-out model. The Commonwealth may need to be involved in order to assist in overcoming any barriers – real or perceived.
- The better <u>intermingling of PH/BH funds</u> within the current carve-out program structure to support more complete and holistic models of value-based purchasing. Again, the Commonwealth's involvement would potentially be needed to support these efforts.
- The carve-in movement should not carry the day based on assertions. There must be <u>hard data</u> and proof from actuarial modeling and other states' experiences in order to justify the complete overhaul of the current program. Further, it must fit Pennsylvania's unique service delivery system and government structure.
- Continue to look for ways within the carve-out model to <u>simplify</u>, <u>standardize</u>, and focus on <u>service outcomes</u>.

The behavioral health carve-out has done a lot of good for consumers and families in the Commonwealth, and that is ultimately what all these programs are about. There has also been a true focus on those with special needs such as adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). To further reach its potential, the program should evolve. It is right for the administration and legislators to push the envelope and ask for change to better achieve such things as integration and a whole-person focus. However, that can be **a call for the evolution of the current carve-out program**, rather than one for dismantling the same.

We strongly urge that policy makers consider the above as we transition into the next generation of HealthChoices, one that can move the carve-out model to be even more successful.

With well over 300 members, the majority of who serve over 1 million Pennsylvanians annually, Rehabilitation and Community Providers Association (RCPA) is among the largest and most diverse state health and human services trade associations in the nation. RCPA provider members offer mental health, drug and alcohol, intellectual and developmental disabilities, children's, brain injury, medical rehabilitation, and physical disabilities and aging services, through all settings and levels of care. Visit <u>www.paproviders.org</u> for more information.

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