
Leveraging the Strengths of the Behavioral HealthChoices Program to Support Integrated Care in Pennsylvania

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Executive Summary

Policymakers in Pennsylvania and across the nation are confronting substantial challenges as they seek to improve health outcomes and access to care for people with behavioral health conditions, especially for people with serious mental illness (SMI) and substance use disorders (SUD). Nearly 40 percent of Medicaid enrollees nationwide live with a mental illness and/or substance use disorder, and most people with SMI and SUD do not receive treatment for these conditions. These individuals face greater risks of poor social outcomes such as homelessness and unemployment, and for being diagnosed with chronic physical health conditions. The lack of preventive physical health care for individuals with concurrent behavioral health conditions leads to much higher health care spending — with national Medicaid spending being approximately four times higher for individuals with SMI or SUD.

Whereas a multipronged policy approach — for example, addressing workforce shortages and overall system capacity — is necessary to address the current behavioral health crisis, improving access to integrated care is one critical component. Due to the interconnected nature of physical and behavioral health along with social needs, improving outcomes for individuals with mental illness or SUD requires coordinated, whole person care. Integrated care can increase access to comprehensive services in the settings where people are most comfortable. In Medicaid, efforts to integrate care vary widely by state depending on the mechanisms for how physical and behavioral health programs are financed and administered. While many states historically operated “carve-out” systems that separately administered physical and behavioral health benefits, over the last decade most states with managed care models have moved toward integrated managed care models to manage all physical and behavioral health services.

There is no one-size-fits-all approach to behavioral health integration across states, given that each state has a different landscape with associated strengths and limitations. Effective approaches to advancing integration require: (1) understanding what works well and where the gaps are within the current system; (2) identifying opportunities to refine policies, infrastructure, and incentives to achieve desired outcomes; and (3) applying relevant lessons and evidence from a national context. Pennsylvania, unlike many states, has a robust county-based infrastructure for managing behavioral health services in concert with other county-managed human services. For decades, the state’s Behavioral HealthChoices Program has served as a platform for county-level innovation to integrate care. Counties and their respective behavioral health managed care organization (BH-MCO) partners have deep expertise in how to manage and deliver care for people with serious behavioral health conditions,

while also attending to their health-related social needs. Yet, this system, as any, has its limitations. There remain critical gaps in access to integrated care for people across Pennsylvania, requiring concerted focus by state policymakers.

This report provides an overview of the national landscape on behavioral health integration as well as of the history and key characteristics of Pennsylvania's Behavioral HealthChoices Program. To explore how the program has impacted access to care and integration of care, the report includes an evaluation of evidence as well as spotlights on innovative programs from Erie, Montgomery, and Philadelphia counties and the Capital Area Behavioral Health Collaborative. The report concludes with six key recommendations to build on the strengths of Pennsylvania's Behavioral HealthChoices system to improve integration and ultimately drive better outcomes for people with behavioral health conditions. It outlines strategies to pursue each of the following recommendations:

1. [Invest in workforce initiatives to expand access to behavioral health treatment.](#)
2. [Increase focus on integration of physical and behavioral health care in multiple delivery settings.](#)
3. [Leverage new federal pathways to address health-related social needs.](#)
4. [Improve data exchange to support whole person care planning.](#)
5. [Improve access to physical and behavioral health services for justice-involved populations.](#)
6. [Improve coordination of behavioral health services for individuals in skilled nursing facilities.](#)

Background: The Need for Integrated Care

Across the country, there is an increasing need for mental health and substance use care (referred to here as behavioral health care). Nearly 40 percent of Medicaid enrollees live with a mental illness and/or substance use disorder, and that percentage has grown in recent years.¹ Most people with SMI and/or SUD do not access treatment for these conditions.^{2,3} People with serious behavioral health conditions are also more likely to experience chronic physical health conditions, poor social outcomes such as homelessness and unemployment, and premature death.^{4,5} In addition, they receive less preventive care and more acute care.^{6,7} Medicaid spending is approximately four times higher for individuals with serious behavioral health conditions, largely due to increased physical health spending.⁸

Pennsylvania compares favorably to other states with respect to mental health care, with annual reports from *Mental Health America* ranking Pennsylvania in the top three states in the nation as measured by rates of access and prevalence of mental illness over each of the past three years.⁹ However, Pennsylvania has one of the highest rates for fatal drug overdose in the country, and fewer total mental health providers per capita than the national average.¹⁰ The urgency of the opioid crisis, the shortage of behavioral health providers, and the rapidly increasing number of individuals reporting anxiety and depression — including children and youth — all point to the need for Pennsylvania to develop a multipronged policy strategy to continue to expand access to behavioral health care to support greater wellness and recovery.

Many states, health plans, and providers are focusing on integration of physical and behavioral health services as a mechanism to address whole-person needs and increase access to services in the settings where people are most comfortable seeking care. Under integrated models of care, teams of providers work to coordinate and deliver patient-centered care that addresses both physical and behavioral health needs.¹¹ There is a strong evidence base for this type of clinical integration, showing that it improves health outcomes and quality of life while reducing health care costs for people across the continuum of behavioral health needs.^{12,13,14} Many providers are also seeking to coordinate services to address health-related social needs as well, since factors such as housing, food insecurity, and financial strain have a deep impact on health and wellbeing.

Pennsylvania is in the top three states in the nation as measured by rates of access and prevalence of mental illness. However, it has one of the highest rates for fatal drug overdose in the country, and fewer total mental health providers per capita than the national average.

National Landscape

In Medicaid, physical and behavioral health historically have been administered separately, with most states — particularly those with managed care programs — “carving out” behavioral health benefits from physical health benefits. In these carve-out arrangements, behavioral health services are either administered by separate managed behavioral health organizations or delivered on a fee-for-service basis. These carve-out models were designed to protect dedicated funding for behavioral health care and focus on improving outcomes and ensuring access to care for people with serious behavioral health conditions. However, many states have transitioned away from carve-out arrangements due to the perceived barriers in delivering integrated care when the care is administered and financed by multiple systems. When there are separate payers for physical and behavioral health care, enrollees must interact with multiple systems, providers may have barriers to communicating and sharing data, and payer incentives may not be fully aligned with integrated care.¹⁵

Over the last decade, most states with managed care models have moved away from carve-outs for people with serious behavioral health conditions, and instead use integrated managed care models to manage all physical and behavioral health services.¹⁶ These system transitions potentially create significant disruption to enrollee access to services and provider sustainability.¹⁷ Moreover, there is currently limited evidence on the impact of these efforts in meeting their clinical integration goals. Four recent studies of carve-in models in Illinois, New York, Oregon, and Washington State show mixed results on how these models impact access to care, utilization, and costs.^{18,19,20,21}

Researchers synthesizing these studies have identified key takeaways that are highly relevant for Pennsylvania:

- **Carve-in and carve-out models have different expected benefits and risks.** Carve-in models are expected to improve clinical integration but risk lower access to services for those with the highest needs; while carve-out models are expected to improve access to specialty behavioral health care but risk lower access to physical health care.²²
- **Both carve-in and carve-out models can be designed to facilitate integration and states vary widely in their approaches.** Key design features — such as those related to contracts, payments, regulations, and administrative processes — can help to advance integration in both types of models.²³ Regardless of the model, it is key to support practice transformation, evidence-based practices, health information technology, and aligned incentives for integrated care.²⁴

- **States should tailor approaches to leverage existing strengths and find opportunities to improve.** As states design integration initiatives, they should identify and preserve what works best in their systems, while identifying system changes that can drive better outcomes.²⁵

Profiles of National Approaches to Improve Integration

National examples show how states advance behavioral health integration from within very different structures. Initiatives in other states offer lessons for Pennsylvania on how to leverage the strengths in existing behavioral health systems, support integration of health-related social needs, and drive payment innovation and infrastructure supports to deliver more integrated care. Highlighted below are examples from California and Arizona — one carve-out state and one carve-in state — and two strong examples of policy initiatives to promote greater integration.

California county behavioral health departments manage specialty mental health and SUD care while Medicaid managed care plans manage physical health and non-specialty mental health services. CalAIM (California Advancing and Innovating Medi-Cal) — which includes a Section 1115 demonstration and Section 1915(b) waiver — incorporates multiple initiatives intended to support greater integration of care within the existing carve-out structure:

- Enhanced care management for select high-need populations, including individuals with serious behavioral health conditions. This new benefit aims to address clinical and nonclinical needs across physical and behavioral health systems.²⁶
- Community supports, which are a group of medically appropriate and cost-effective alternatives to state plan services that can be implemented voluntarily by managed care organizations. The 14 community supports, such as housing-related services and meals, are designed to support individuals with complex health-related social needs such as homelessness.²⁷
- Pre-release coverage of an array of physical and behavioral health services for justice-involved populations, up to 90 days prior to reentry.²⁸

Together, these initiatives show pathways to further the integration of care within a “carve-out” system that separately administers physical and behavioral health.

Arizona has integrated managed care organizations and has focused on facilitating integration at the provider level and expanding health-related social needs services to more effectively meet the needs of people with serious behavioral health conditions.

The state’s Targeted Investment (TI) program provides incentive payments for providers (primary care, mental health, and hospital) to integrate and coordinate physical and behavioral health care at the point of service.²⁹ The state incorporates TI payments into managed care capitation rates, and managed care organizations provide incentive payments to providers that meet defined targets. Providers are rewarded for performance on outcome measures as well as for developing infrastructure and protocols to support integrated care, such as participating in bidirectional data-sharing. The state has reported that the TI program has spurred growth in the number of integrated care clinical providers and increased use of trauma-informed care protocols, among other impacts.³⁰ The original rollout included \$300 million over five years, and a second phase of the program, with total funding not to exceed \$250 million, has now been approved by the Centers for Medicare & Medicaid Services and will extend through 2027.^{*} In the second phase, providers will be rewarded for improving quality and health equity by addressing health-related social needs, including through implementation of closed loop referral systems.

Arizona is also expanding coverage for health-related social needs for individuals experiencing homelessness and those with complex needs such as serious mental illness. Newly covered housing services will include rent/temporary housing for up to six months for individuals transitioning from institutional or congregate settings into community settings.³¹ These services are designed to improve health outcomes, reduce disparities, and address the upstream drivers of high costs.

Overview of Behavioral HealthChoices

Pennsylvania’s Behavioral HealthChoices program is a uniquely designed carve-out model, administered by the state Office of Mental Health and Substance Abuse Services (OMHSAS.) Counties are programmatically and fiscally responsible for HealthChoices-funded behavioral health under this program, in addition to their responsibilities for county-administered human services such as child welfare, housing and homeless services, schools, criminal justice, and intellectual and developmental disability services. Pennsylvania began this program in 1997, building on Pennsylvania counties’ long history of overseeing behavioral health services, with the goals of improving care for people with behavioral health conditions and achieving more spending predictability. Counties in Pennsylvania have the “right of first opportunity” to manage the delivery and financing of Behavioral HealthChoices mental

^{*} For comparison, the population of Medicaid enrollees is approximately 2.8 million in Arizona versus 3.65 million in Pennsylvania. Source: “[Total Monthly Medicaid & CHIP Enrollment and Pre-ACA Enrollment.](#)” Kaiser Family Foundation. November 2022.

health and substance use care under this program, which enables counties to leverage their long history of administering behavioral health services under state law.

Counties that opt in receive a capitation payment and are at-risk for all costs of behavioral health care, with the flexibility to either manage internally or contract with an administrative services organization or risk-based behavioral health managed care organization (BH-MCO). These options are intended to allow counties to apply their specialized expertise in behavioral health and human services based on their unique infrastructure and capacity. Currently, all counties have accepted the right of first opportunity, whether individually or through county collaborative arrangements.

Some key elements of the Behavioral HealthChoices program include:

- **Using reinvestment to address gaps in services and strengthen system capacity.** Counties reinvest savings of up to three percent of unspent capitation funds into improvements in services and treatment approaches beyond those covered by Medical Assistance (also known as Medicaid), while all savings beyond three percent are returned to the state. Since the inception of Behavioral HealthChoices, counties have reinvested over \$844 million in services as of 2018, including evidence-based adult and youth behavioral health services, housing supports, and supported employment.³² Reinvestment programs spur local innovation to respond to local needs, and have also helped to identify priorities for expanded statewide benefits.
- **Combining different sources of funding to maximize impact.** In addition to providing covered behavioral health services for Medical Assistance enrollees, counties are responsible for providing services not covered by Medical Assistance, as well as services to people not enrolled in Medical Assistance. For example, counties ensure access to a continuum of crisis services for all county residents. Counties can braid Behavioral HealthChoices funding with other federal, state, and county funding for mental health and substance use care to leverage all funding sources and efficiently design programs.

Impact of Behavioral HealthChoices on Health and Cost Outcomes

While the high overall national ranking for mental health care in Pennsylvania is not solely focused on Medical Assistance, the Behavioral HealthChoices program contributes significantly, given that Medicaid is the largest payer for behavioral health nationwide.³³ State officials have estimated that the Behavioral HealthChoices program has yielded statewide cost savings between \$11 to \$14 billion from the program's inception through 2016, in comparison to the pre-existing fee-for-service program.³⁴ The

program also demonstrates administrative savings, as shown by the estimated medical loss ratio for Behavioral HealthChoices statewide of over 90 percent, which exceeds requirements for physical health MCOs.³⁵ The reinvestment program is designed to channel savings back into improved and enhanced services. While it can be challenging to measure integration of physical and behavioral health care, it is notable that Pennsylvania ranks in the top 25 percent of states on select quality measures related to integration, such as diabetes screening and medication adherence for persons with schizophrenia.³⁶

Advancing Integration within Behavioral HealthChoices

The structure of the Behavioral HealthChoices program both facilitates and creates challenges for integration. On a local level, county planning for management and delivery of Medical Assistance behavioral health services allows for integration of behavioral health with county-managed human services, enabling innovative approaches to reaching individuals with the most complex behavioral health needs — such as foster youth, people with a criminal justice history, or people with intellectual or development disabilities. Examples of these integration strategies are provided later in this report. However, since physical and behavioral health benefits are managed by separate entities, the respective plans and providers can face barriers in accessing comprehensive data across physical and behavioral health needs. Development of value-based payment approaches inclusive of physical and behavioral health is also challenging given the different payment mechanisms.

Specific requirements within the HealthChoices program, such as facilitated data exchange, community-based care management, integrated care programs, and Centers of Excellence for opioid use disorder, have been designed to address these challenges and advance integration. These programs are implemented at the county level and tailored to address local needs.

- **Facilitated data exchange** has been a priority across the HealthChoices program for over a decade. During this time, the Pennsylvania Department of Human Services (DHS) has worked to support data sharing across its the physical health and behavioral health managed care organizations (PH- and BH-MCOs). DHS sends encounter files of all behavioral health claims to the PH-MCOs, and all physical health claims including pharmacy to the BH-MCOs on at least a monthly basis. These files have some limitations given that SUD data are excluded for confidentiality; however, recent amendments to state privacy laws may enable greater inclusion of SUD data going forward. In addition, DHS requires that all PH- and BH-MCOs contract with at least one statewide health information organization to exchange admission, discharge, and transfer (ADT) notifications.

- **Community-Based Care Management (CBCM)** program began in Behavioral HealthChoices in 2021 with requirements for BH-MCOs and counties to develop programs to engage high-risk members with the goals of improving care coordination and increasing use of preventive care to improve behavioral health outcomes and reduce disparities. Counties and BH-MCOs may also partner with their respective PH-MCOs, which have similar CBCM requirements, as they design programs to address local priorities. Within this initiative, counties can directly support community-based organizations to address health-related social needs. For example, the Capital Area Behavioral Health Collaborative (CABHC) in central Pennsylvania has funded community health workers based in federally qualified health centers (FQHCs) to support members with social service needs and provide linkages to behavioral health, physical health, and community resources. As part of this model, CABHC provides funding to the FQHCs and community-based organizations to purchase social services on members' behalf, including support for utilities, rent, transportation, and food access.
- **Integrated Care Program** began in 2016 with the goal of providing financial incentives to the PH-MCOs and BH-MCOs to better coordinate physical and behavioral health care for people with SMI and those with SUD. Both BH-MCOs and PH-MCOs receive bonus payments if they achieve set goals for members receiving an integrated care plan across both the PH- and BH-MCOs, reviewing and updating those plans at least annually, and reaching benchmarks for performance measures such as medication adherence, readmission rates, and diabetes screening for persons on antipsychotic medications, among others. OMHSAS has reported significant improvements in most of the quality measures.³⁷ For example, the Erie County BH-MCO is notified when a program participant has an emergency department or acute care encounter, so that care managers can immediately begin reaching out to the member to help coordinate their care.
- **Centers of Excellence (COEs)** for opioid use disorder were introduced in 2016 to address the state's high rate of drug overdose. All selected COEs, which include primary care practices, hospitals, and SUD treatment providers, provide whole-person care for people with opioid use disorder. BH-MCOs and PH-MCOs coordinate to pay COEs a bundled payment for care management services. The COE structure and payment model creates opportunities for counties to innovate and lead the development of partnerships to better integrate physical and behavioral health. For example, Montgomery County has responded to increased needs for wound care among patients at an SUD residential facility by facilitating a partnership with a COE operating through a federally qualified health center. This partnership supports greater care for these patients following discharge from the residential facility into the community. The county is also piloting joint clinical reviews between the BH- and PH-MCOs for individuals receiving care from the COEs.

Given the county-based structure of the program, it is particularly informative to look directly to the counties to understand how the Behavioral HealthChoices platform is supporting integrated care, and what policy changes could support further integration of care in the future. Each county and BH-MCO partnership designs integrated care initiatives to address local priorities and to leverage the diverse funding sources and unique capacities of the partners. Following are brief descriptions of select county-based approaches.

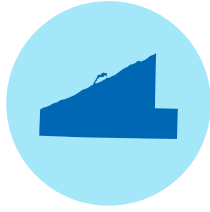


Capital Area: Increasing Access to School-Based Behavioral Health Services

The Capital Area Behavioral Health Collaborative (CABHC) is an organization that contracts with the state on behalf of Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties. CABHC is at risk for all Medical Assistance behavioral health services, and contracts with PerformCare to serve as its administrative services organization (BH-MCO).

CABHC has partnered closely with schools across these five counties to provide school-based services with the goal of engaging children and their families in community settings to increase access to care. CABHC embeds behavioral health clinicians in each school district, covering more than 150 school buildings. These clinicians have office space to provide outpatient counseling for children and their families. CABHC reports that approximately one-fifth of all behavioral health claims for school-age children were for services provided in these school-based settings.³⁸ CABHC has also facilitated targeted outreach, in partnership with schools, to proactively engage children struggling in school to identify potential behavioral health concerns for the child or their family and connect them with specialized services, such as a school-based SUD outpatient treatment programs.

These school-based programs increase access to behavioral health services for children and youth and are enabled by the Behavioral HealthChoices structure and funding platform. Counties are well-positioned to integrate behavioral health into human services settings such as schools due to strong relationships between local officials that create opportunities for innovative partnerships. Not all children and families served by school systems are eligible for Medical Assistance. CABHC can braid together funding from Behavioral HealthChoices with county base funding to maximize coverage and strengthen community-based connections to care.



Erie County: Addressing Gaps in Care for People with Complex Needs

Erie County subcontracts with Community Care Behavioral Health (CCBH) as the county’s BH-MCO. CCBH is a part of the UPMC Insurance Services Division, which also operates UPMC for You, a separate PH-MCO. CCBH and Erie County have implemented programs to better identify which members may be at risk for having poor outcomes — and then invest in the care delivery infrastructure to deploy the services that members need.

Erie County has worked with CCBH to better integrate physical and behavioral health care as well as care for health-related social needs, including through implementation of a high-risk readmission interview tool for people receiving inpatient behavioral health services. This tool has been designed to assess whole-person care needs and identify gaps in care to be addressed, particularly given the risks to care continuity associated with transitions from one setting to another. This tool is implemented by CCBH’s care management team, with collaboration from county staff and local behavioral health providers to identify opportunities to support members with community-based treatment, housing, and employment opportunities. A study of this care management approach found that participants had lower rates of readmission to SUD acute care and better connections to mental health and SUD services post-discharge.³⁹

In addition to improving individual care, these collaborations in Erie County have also identified when care coordination is not enough, and new programs are needed. For example, Erie County identified the need for an interim level of care between inpatient care and state hospitals, and invested in the development of a long-term structured residential treatment center where patients can stay for up to six months. The county funded this program by combining Behavioral HealthChoices funding for the treatment with county-base funding to pay for room and board. County-level oversight and close working partnerships with CCBH and providers enabled the identification of this service gap, and the flexibility to braid multiple funding sources allows for this type of investment in the care delivery infrastructure.



Montgomery County: Addressing Whole Person Care Across Medical and Social Needs

Montgomery County oversees the Behavioral HealthChoices program, contracts with Magellan Behavioral Health of Pennsylvania as its BH-MCO, and collaborates closely across county human service offices to ensure an integrated approach. Recent initiatives to implement a whole person approach to care have built on a strong history of physical-behavioral health integration initiatives. In 2009, Montgomery County launched a pilot project focusing on physical-behavioral health integration for people with SMI, which led to reductions in physical health emergency department costs of nearly 70 percent.⁴⁰

In recent years Montgomery County has continued to build on these foundations through various investments in integrated care:

- The county has designated six Community Behavioral Health Centers (CBHCs), using a health home model. Most of these CBHCs have wellness recovery teams with a nurse, behavioral health provider, and navigator. These teams emphasize an integrated, trauma-informed approach with coordination of behavioral and physical health care. Three of the six Montgomery County CBHCs are participating in the federal Certified Community Behavioral Health Center demonstration, which includes requirements for physical health screenings in addition to comprehensive behavioral health care.⁴¹
- Magellan has implemented an Integrated Health Care Management Team, which provides targeted support to members with physical and behavioral health needs, coordinates care with the PH-MCOs and Community HealthChoices MCOs (CHC-MCOs), and provides resources and education to members. Community HealthChoices is the mandatory managed care program for individuals who are dually eligible for Medical Assistance and Medicare, and individuals with physical disabilities.⁴²
- Under its “Whole Care Pilot,” Magellan identifies members missing key medical labs and collaborates with behavioral health providers to engage primary care providers and address care gaps.

The health and human services structure in Montgomery County enables a strategic approach to address resident needs in a holistic manner. Beyond integration of physical and behavioral health care, Montgomery County has multiple initiatives focused on integration of health-related social services. In particular, given the significant housing needs for people with serious behavioral health conditions, Montgomery County has prioritized its reinvestment spending since 2004 on housing initiatives, including a program to provide capital for rental housing development and rental subsidies. This

program has resulted in the development of over 50 rental units for people with mental health conditions, with those housing units guaranteed for 30 years.⁴³ Other programs to address housing and food insecurity have braided funding across county human services funds, reinvestment, and Behavioral HealthChoices community-based care management projects.



Philadelphia County: Addressing Behavioral Health Needs Across the Lifespan

Upon the launch of Behavioral HealthChoices, Philadelphia established a county-controlled entity, Community Behavioral Health (CBH), to serve as the BH-MCO. Across a range of initiatives and settings, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with CBH to develop innovative approaches to embedding behavioral health providers and staff into non-traditional settings to increase access to treatment. Of particular note, CBH and DBHIDS employ tailored approaches for specific sub-populations, ensuring access to integrated care in the settings that work best for them.

For example, CBH identified the opportunity to address the maternal mental health crisis by integrating mental health care in maternity care settings by funding a clinician and peer support specialist to be embedded within each of the city's birthing hospitals. These providers assess behavioral health and social needs and refer to other programs and services as warranted to improve behavioral health outcomes for pregnant, postpartum, and inter-conception women. Likewise, CBH credentialed the Philadelphia School District as a contracted CBH provider to expand access to school-based behavioral health services, while also funding and managing other behavioral health providers embedded in district schools. Using a combination of outplaced staff and funding, CBH has also embedded behavioral health clinicians in settings including family courts, federally qualified health centers, and city health clinics.

CBH and DBHIDS have also focused on older adults. Older adults with SMI who need nursing facility-level care often struggle to find placement and are at risk of discharge due to safety concerns. As a result, many do not receive high-quality care for their physical or behavioral health needs. CBH has partnered with the city of Philadelphia, acute, long-term care, behavioral health providers, area agencies on aging, advocacy groups, and others to develop a new program to support skilled nursing facilities in providing structured supplemental behavioral health services for residents with SMI. This collaboration led to the design of a new CBH reimbursement model, which will fund defined behavioral health services in these facilities, while fully aligning with Community HealthChoices.⁴⁴ The program is expected to launch in 2023 and aims to be a model for expansion across Pennsylvania and the country.

Recommendations

Counties and BH-MCOs in Pennsylvania have partnered closely with each other and other stakeholders to advance more integrated care for individuals with behavioral health conditions and create responsive and innovative approaches to delivering new programs. At the same time, Pennsylvania’s counties and BH-MCOs have also encountered numerous barriers to delivering integrated care for specific populations, addressing infrastructure challenges such as workforce shortages and data exchange, and more deeply integrating care across physical health and social needs. Pennsylvania has opportunities to address these barriers with the goal of delivering more comprehensive whole person care for Medical Assistance enrollees.

The recommendations below include broad opportunities to build on the strengths of the HealthChoices system, leverage new federal flexibilities, and pursue policies that will facilitate integration.

1. Invest in workforce initiatives to expand access to behavioral health treatment.

In Pennsylvania and across the United States, behavioral health workforce shortages limit access to behavioral health care across a variety of settings, including community behavioral health, primary care and other health care institutions, and schools. Workforce shortages have multiple causes, but many of the competitive disadvantages that behavioral health professions currently face can be addressed through targeted efforts to address recruitment and retention. The recent Pennsylvania Behavioral Health Commission special report recommends prioritizing these opportunities.⁴⁵ Strategies could include:



- a. **Expanded reimbursement options for peer support services**, such as through bundled care management payments, which could increase deployment of certified peer specialists and certified recovery specialists.
- b. **Tuition assistance or reimbursement programs**, to reduce the cost of entry into the behavioral health profession.
- c. **Training and education initiatives**, in partnership with state and local higher educational institutions, to provide career pathways and opportunities for higher levels of credentialing and wages.
- d. **Engagement with state licensing boards** to reconsider licensing requirements, identifying opportunities to accelerate the timeline for getting practitioners such as licensed clinical social workers in the field.

2. Increase focus on integration of physical and behavioral health care in multiple delivery settings.

To expand access to behavioral health treatment, services need to be available in the broad array of settings wherein individuals may seek care, particularly given the lingering stigma associated with mental illness and substance use disorders. Behavioral health services should be widely available in primary care and schools, and physical health services should similarly be accessible in community behavioral health centers. At a minimum, people should have access to screening and referral services in their setting of choice, and as noted in the Behavioral Health Commission Special Report, the need for integrated care delivery is particularly acute in rural counties.⁴⁶ The examples highlighted across the counties mentioned in this report can be widely replicated across the state, through the following strategies:



- a. Increase accountability among PH-MCOs and BH-MCOs** for ensuring access to integrated care among their provider networks. While good strides have been made in promoting integration efforts among the PH- and BH-MCOs, these efforts need to flow down to the provider level where care is actually delivered.
- b. Promote adoption of integrated delivery approaches at the practice level** including but not limited to the Collaborative Care Model. In particular, more resources are needed to support investments in infrastructure development (e.g., team-based care, electronic health record adoption, and health information organization connections) and associated technical assistance centers to facilitate implementation. Funding is also needed to implement performance incentives to providers related to integrated care.
- c. Increase funding for 988 services**, which provide new opportunities to identify and address needs earlier in their emergence. In particular, more resources should be directed to community-based response teams that can identify and address not only behavioral health needs, but physical health and social service needs as well.

3. Leverage new federal pathways to address health-related social needs (HRSN).

In Pennsylvania and beyond, there is increased appreciation for the role of social determinants of health and growing interest in leveraging federal Medicaid funds to provide targeted access to these services. Many vehicles that already exist in the HealthChoices program can be expanded or more effectively utilized, and recent actions by federal partners at the Centers for Medicare & Medicaid Services (CMS) provide new pathways that Pennsylvania should consider for implementation:



a. Promote broad and more consistent investment in HRSN services through existing gain-sharing and reinvestment requirements with PH- and BH-MCOs.

Whereas reinvestment has long been a part of the Behavioral HealthChoices program, similar requirements have been newly added to the PH-MCOs as of 2023. This alignment creates new opportunities for coordinated investments in community capacity. The state can support these efforts by developing standard menus of allowable uses of funds, promoting collaboration across PH- and BH-MCOs, and encouraging the MCOs to seek input from community members in developing reinvestment strategies.

b. Encourage voluntary in-plan coverage of a defined set of HRSN services by PH- and BH-MCOs through “in lieu of services” authority, for which CMS released updated guidance in January 2023.⁴⁷ Through this approach, Pennsylvania could provide a standard menu of allowable HRSN services for the MCOs to choose to cover, along with federally matched Medical Assistance funds to support them.

c. Seek an 1115 waiver to create new statewide HealthChoices benefits for housing and nutrition services. As recently approved in Arizona and Massachusetts, such a waiver would allow Pennsylvania to offer services such as rental assistance, housing navigation and transition supports, and medically tailored meals, with a particular focus on populations transitioning from institutional settings into the community.⁴⁸

4. Improve data exchange to support whole person care planning.

Clinicians and system administrators often lack access to the array of data they need to support integrated care planning and care coordination. While some data sharing is mandated to occur between PH- and BH-MCOs as noted above, this information does not always make its way to providers at the point of care. Not all providers are connected to regional health information exchanges (HIEs), and most regions lack data systems that connect with community-based social service providers. A number of initiatives are underway to improve data-sharing, and additional efforts could provide important enhancements:



a. Support ubiquitous connections to HIEs among behavioral health providers.

The majority of behavioral health providers in Pennsylvania are not connected to the Pennsylvania Patient and Provider Network Certified Health Information Organization.⁴⁹ The HealthChoices program should provide incentives and other technical assistance supports as needed to ensure this connectivity.

- b. Align provider quality reporting requirements and related incentives across the PH-MCOs, BH-MCOs, and Community HealthChoices programs,** to improve coordination of care, standardize tracking of outcomes across the system, promote stakeholder alignment, and reduce administrative burden. Many of these quality metrics are already defined in the Integrated Care Program and the Medicaid adult/pediatric core quality measure set; funding for provider-level incentives would increase accountability at the point of care.
- c. Continue efforts to implement PA Navigate (formerly known as RISE-PA),** through which the state’s health information exchanges will integrate a common resource and referral system for community-based HRSN services. The platform is expected to go live in 2023.

5. Improve access to physical and behavioral health services for justice-involved populations. A disproportionate number of individuals with criminal justice system involvement have behavioral health needs. Unmet needs for mental health or substance use disorder treatment can be pathways to incarceration, and lack of sufficient physical or behavioral health care while incarcerated or upon reentry into the community can lead to poor health outcomes and alarmingly high mortality rates post-release, including high rates of overdose deaths.⁵⁰ Accordingly, many states are focused on improving access to services to both divert individuals where appropriate from incarceration, and improve the likelihood of successful reentry upon release in the community. Following a report to Congress on the evidence supporting efforts to coordinate access to services for justice-involved populations who are returning to the community, CMS recently approved California’s request to provide an array of Medicaid-covered services up to 90 days pre-release, and is expected to provide further guidance to states in the months ahead.^{51,52} These services aim to identify and stabilize health needs prior to release, and ensure appropriate connections to community-based care upon reentry.



- a. Promote broad and more consistent investment in HRSN services through existing gain-sharing and reinvestment requirements with PH- and BH-MCOs.** Whereas reinvestment has long been a part of the Behavioral HealthChoices program, similar requirements have been newly added to the PH-MCOs as of 2023. This alignment creates new opportunities for coordinated investments in community capacity. The state can support these efforts by developing standard menus of allowable uses of funds, promoting collaboration across PH- and BH-MCOs, and encouraging the MCOs to seek input from community members in developing reinvestment strategies.

- b. Encourage voluntary in-plan coverage of a defined set of HRSN services by PH- and BH-MCOs through “in lieu of services” authority**, for which CMS released updated guidance in January 2023.⁵³ Through this approach, Pennsylvania could provide a standard menu of allowable HRSN services for the MCOs to choose to cover, along with federally matched Medical Assistance funds to support them.

6. Improve coordination of behavioral health services for individuals in skilled nursing facilities (SNFs).

Individuals receiving long-term services and supports, and particularly those in SNFs, have unique barriers to accessing some community-based behavioral health services. While many individuals in SNFs receive behavioral health treatment from psychiatrists, most SNFs do not have established relationships with community-based behavioral health agencies, nor their own staffing to provide “non psychiatrist” behavioral health services onsite. In addition, given that Medicare is the primary payer for physical health services and Medicare-covered behavioral health services for many CHC enrollees, efforts to integrate care across the various managed care entities would be enhanced by direct data sharing between Medicare MCOs and the BH MCOs.



- a. Incentivize both CHC-MCOs and SNFs to enhance utilization of community-based behavioral health services.** Pennsylvania DHS has a strong history of leveraging pay-for-performance initiatives to drive targeted quality improvement efforts and could identify opportunities to use these tools to improve access to behavioral health services for CHC members.
- b. Insert additional coordination of care requirements in the CHC MCO contracts and with the state contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).** Additional requirements could build on existing data sharing requirements between the CHC MCOs and D-SNPs, and be used specifically to promote improved data-sharing and coordination with the CHC-MCOs and BH-MCOs to collectively ensure that individuals dually eligible for Medicare and Medicaid receive the full array of physical, behavioral health, and long-term services and supports that they need.

Conclusion

While many states and stakeholders are collectively focused on opportunities to deliver more integrated, person-centered care for people with behavioral health conditions, there is no single one-size-fits all approach for all states. Pennsylvania’s robust county-based infrastructure for managing behavioral health services alongside other county-managed human services has enabled Behavioral HealthChoices to become a platform for innovations to integrate care. As Pennsylvania looks to the future and designs approaches to support the health and recovery of people with behavioral health conditions, stakeholders can build on the strong foundation of Behavioral HealthChoices and incorporate county as well as national lessons on how to refine policies, infrastructure, and incentives to promote integration at the point of care. There are numerous and compelling opportunities to build on the current system in ways that could meaningfully promote more integrated care delivery for Medical Assistance enrollees.

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