PA House of Representatives
Republican Policy Committee

414, Main Capitol Building
Harrisburg, PA 17120
(717) 260-6144

**Rep. Joshua D. Kail**
Chairman

**PA House Republican Policy Committee Hearing**

**"Addressing the Mental Health Needs of Rural Communities"**

**September 7, 2023, at 10 a.m.**

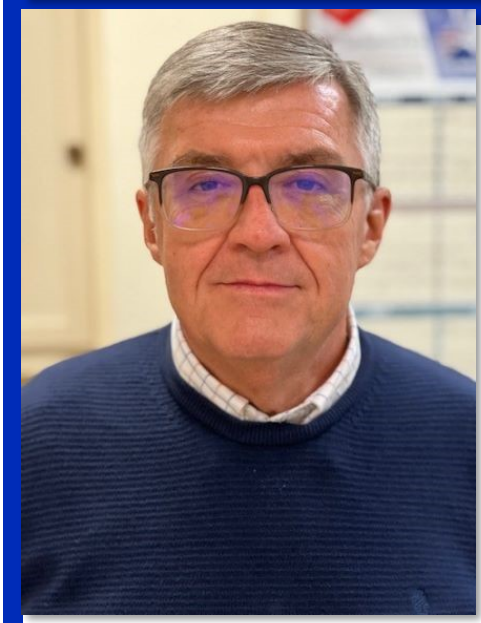
**Pennsylvania College of Technology**
**Mount Laurel Room**
**One College Avenue**
**Williamsport, PA 17701**

| | |
|---|---|
| 10:00 a.m. | Welcome and Pledge of Allegiance |
| | **Navigating Mental Health Services Panel** |
| 10:10 a.m. | Keith Wagner<br>*Executive Director, Lycoming Clinton Joinder* |
| 10:15 a.m. | Ryan Gardner<br>*Lycoming County District Attorney* |
| 10:20 a.m. | Questions for Navigating Mental Health Services Panel |
| | **Empowering Mental Health Solutions Panel** |
| 10:50 a.m. | Sherry Shaffer<br>*Chief Operating Officer & Government Programs Officer of Community Care Behavioral Health, UPMC Insurance Services Division* |
| 10:55 a.m. | Dr. Eric Briggs<br>*Superintendent, South Williamsport Area School District* |
| 11:00 a.m. | Questions for Empowering Mental Health Solutions Panel |
| 11:30 a.m. | Closing Comments |

# Testifier Biographies

PA House of Representatives Policy Committee Hearing

*"Addressing The Mental Health Needs of Rural Communities"*



## Keith Wagner
## Executive Director, Lycoming-Clinton Joinder Board & Administrator, Lycoming-Clinton MHID Programs

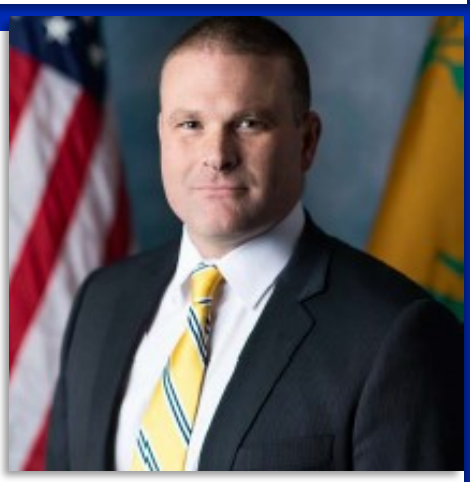
Keith Wagner is the Executive Director of the Lycoming-Clinton Joinder Board Programs. The Joinder oversees the bi-county mental health, intellectual disabilities, and early intervention services as well as the behavioral HealthChoices Program and Lycoming County's Children and Youth Services. Mr. Wagner has worked in human services for nearly 40 years including the past 33 years at the Joinder Board Programs.

During his career Mr. Wagner has been a drug and alcohol treatment specialist for the bi-county SCA, West Branch Drug and Alcohol Abuse Commission, a case worker for Lycoming Children & Youth Services, and a program specialist for Mental Health and Intellectual Disabilities. He was the Joinder's Operations Director for over a decade before becoming the Administrator of the bi-county's Mental Health, Intellectual Disabilities, Early Intervention, and Behavioral HealthChoices Programs in 2016.

Mr. Wagner, in partnership with the Administrator of Lycoming Children & Youth Services and the Executive Director of BLaST IU 17, recognized the impact of trauma in the lives of individuals receiving services and supports from their respective Agencies and sought to move the bi-county's human services toward a trauma-informed care model that asks, 'what happened to you' rather than 'what's wrong with'. The Joinder Board and BLaST contracted with the Andrus Sanctuary Institute of New York to train their employees in the trauma-informed care model. The Joinder received final certification as a Sanctuary Model Trauma-informed Care agency in early 2023.

Mr. Wagner received a bachelor's degree in history from Penn State University and a bachelor's degree in information technology from the Pennsylvania College of Technology. He is currently on the PCoRP Board of Directors and is active on the Community Theatre League Board of Directors in Williamsport, serving as the Vice President. He co-chairs the bi-county human services advisory board as well as the mental health sub-committee of the Criminal Justice Advisory Board in both Lycoming and Clinton County.

## Ryan C. Gardner
## Lycoming County District Attorney

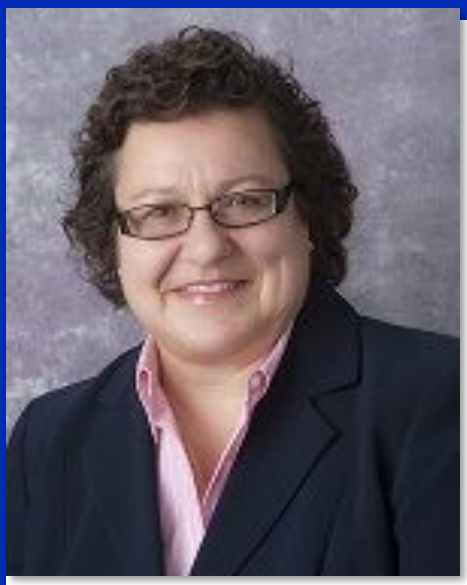


District Attorney Gardner has made family safety a top priority. Gardner led the fight against gang violence and drug activity, teaming up with the FBI, PA State Police, and the NEU to dismantle the "400 Gang" and has continued to assist law enforcement with the identification and prosecution of other local non-traditional gangs.

He also took a hardline stance against sex crimes and sex trafficking, especially sex crimes committed upon our children. During his tenure as District Attorney, Gardner's Office has secured the lengthiest sentences ever imposed upon countless sex offenders in this County. Also, to combat violent crimes and sex crimes, Gardner created several new programs that are overseen by County Detectives including countywide Drone Emergency Response and Digital Forensics Unit Programs.

## Ryan C. Gardner
## Lycoming County District Attorney (cont.)

Finally, Gardner has worked closely with local Law Enforcement not only to promote public safety, but also to help build trust within the community. Gardner used drug forfeiture monies to pay for body cameras for County Detectives, organized several trainings on the topic of de-escalation techniques and provided thousands of dollars to the State Police and municipal police departments to further the training of officers.



## Sherry Shaffer
## Chief Operating Officer and Government Programs Officer of Community Care Behavioral Health, UPMC Insurance Services Division

People can and do recover from behavioral health conditions.
At Community Care Behavioral Health, we believe that recovery from a mental health condition or a substance use disorder is possible. Everyone should have a voice in their treatment.

Our goal is to improve your health and well-being. We aim for this goal by helping you get the right behavioral health treatment that meets all of your needs.

We believe that you should live a life of meaning and purpose. We want you to reach goals that mean something to you on your path to recovery. We help adults, youth, and children who have Medical Assistance. The people who get our services are called Community Care "members."

## Dr. Eric Briggs
## Superintendent of South Williamsport Area School District

Briggs previously worked as the superintendent for the Canton Area School District, a position he has held since 2016. Prior to that role, he was the supervisor of special education of the BLaST Intermediate Unit 17 for twelve years. He also held previous roles as an emotional support teacher for Baltimore Public Schools.

Briggs received his Bachelor's degree in elementary and special education from Lock Haven University in 2000. He would go on to receive his Master's degree in alternative education in 2006, also from Lock Haven. He then received his doctorate in special education from Slippery Rock University in 2018.

HOUSE REPUBLICAN POLICY COMMITTEE
SEAL OF THE HOUSE OF REPRESENTATIVES OF PENNSYLVANIA

I want to thank representative Flick for arranging this House Republican Policy Committee Hearing today and all the Committee members for coming to our bi-county for this discussion. I am Keith Wagner, and I am the Administrator of the Lycoming and Clinton Counties Mental Health & Intellectual Disabilities Program. We are a bi-county Joinder responsible for the bi-county mental health, intellectual disabilities, and early intervention services as well as oversight of the bi-county behavioral HealthChoices Program.

We are here today to discuss the mental health needs of rural communities like Lycoming and Clinton Counties. If you've read a newspaper or magazine in the past few years or watched a news program on television or online, it's likely you've read or heard something along the lines of 'the mental health system is failing' or 'the mental health system is collapsing' or 'the mental health system is broken'.

As the Mental Health Services Administrator, I am reluctant to admit that all those statements are often true, because I know that the men and women who work in the mental health system are doing all they can to keep the system afloat. They are not failing. From mobilizing treatment and medication management in the home, the school, and the community to working with landlords and employers to ensure that people don't lose their housing or their employment because of their illness, to working with the county criminal justice system, hospitals and school districts in specialty courts, high risk case reviews, and cross-service system meetings the level of creativity, ingenuity, and adaptability is amazing.

And yet, all those statements are often true. The mental health system is, in fact, in deep trouble. For rural counties, like Lycoming and Clinton, the mental health system has deteriorated to the point that we are in constant crisis. Band-aiding what we can and watching in frustration as some of our most vulnerable citizens and their families suffer needlessly. For example, during the past decade (2010 to 2020), the suicide rate in Lycoming County increased 65% from the previous decade. The number of inmates in the Lycoming County prison with an active mental illness steadily increased over the decade and currently hovers around 40% of the total inmate population. Every school district in the bi-county has numerous mental health specialists working in the schools every day from outpatient therapists and case managers to intensive behavior modification specialists and crisis interventionists. Access to a psychiatrist, especially for children, is severely limited and often involves lengthy waitlists and travel time and is increasingly only available virtually.

The Lycoming-Clinton Joinder serves a combined population of 151,638 lives in an area covering 2,141 square miles, which is a larger area than 2 US States. Lycoming County itself covers the largest geographic area in the state, while Clinton County is the 15$^{th}$ largest. However, the population density in the bi-county is only 71 people per square mile. By comparison, Dauphin County has 520 people per square mile and nearby Centre County has 147 people per square mile. I mention this because it directly relates to the most significant barriers for rural counties to providing effective mental health services: population, access, and funding.

In fact, the issues with population, access, and funding are intertwined. There are two primary funding sources that pay for most mental health services in Pennsylvania, State Mental Health Base Allocation and Medicaid. The amount of State Base Allocation and Medicaid funds each county or bi-county receives is based on either the total county population or the number of lives enrolled in Medicaid in the county. For rural counties like Lycoming and Clinton where there's fewer people, there's less funding. With less funding, there's fewer services. When there's fewer services, the population goes untreated and ends up impacting other systems like the schools, hospitals, and criminal justice system.

Added to that is the greater distances individuals often travel to reach services in rural communities and the lack of public transportation. Also, there is a stigma associated with needing mental health services, in general, that is compounded in rural communities where the likelihood of being seen seeking mental health services by someone you know is higher. Finally, there is the general stagnation of funding for mental health services and the declining workforce leading to staff shortages, both of which are exacerbated in rural counties that continue to see a shrinking census.

What can we do?

- **Make a multi-year commitment to increase base funding for Mental Health. Lycoming-Clinton's Mental Health Allocation is less today than it was in 2006 and has been stagnant for years.**
- **Increase PA Behavioral HealthChoices funding to allow higher rates for services for rural communities to help offset the smaller population.**
- **Consider moving mental health services' budgeting process to a need's-based model like Child Welfare's.**
- **Explore ways to provide education expense relief and/or incentives to attract young people to the field. Options could include Student Loan Relief for Mental Health Workers in Rural Counties; tuition payment or reimbursement and stipends for individuals willing to seek BSW, MSW, and other higher degrees in exchange for a commitment to work in the county mental health system like the CWEL/CWEB programs.**
- **Explore modifying education requirements for some mental health specialties, especially child psychologists, to allow licensing with a master's degree as had been the practice in the past.**
- **The practice of providing mental health funding to other systems, for example the school districts and the court system, without also providing increased funding to the mental health system or at least linking the funding to the mental health system has to stop as it risks exacerbating the current mental health system crisis by creating parallel systems and further straining the limited staffing resources.**

Thank you.

Written Testimony of Ryan C. Gardner Regarding September 7, 2023 Policy Hearing 'Addressing the Mental Health Needs of Rural Communities.'

My name is Ryan Gardner and I am currently the elected District Attorney of Lycoming County. I have held this position since January 2020 and during my almost four year tenure, I have had occasion to witness and experience the frustrations of law enforcement, prosecutors and defense counsel regarding the insufficient availability of resources to individuals afflicted with mental health issues and simultaneously confronted with criminal charges.

The easiest manner in which to explain these frustrations is by dividing the analysis into two parts. The first part will discuss the frustrations experienced by law enforcement when an officer is dispatched to a disturbance or situation involving an individual experiencing a mental health episode. The second part will discuss the frustrations realized by prosecutors and defense attorneys in a post-arrest/pre-trial posture.

First, law enforcement continues to undertake significant efforts to better identify individuals afflicted with mental issues when responding to an active crime scene as well as exercise de-escalation techniques after arriving on scene when dealing with an individual afflicted with MH issues. Law enforcement routinely engages in trainings and seminars to educate themselves on a wide range of topics including mental health. Unfortunately, despite the best efforts of law enforcement to capitalize on the educational resources available to them, more often than not when an officer is dispatched to a situation involving an individual afflicted by mental health issues, the officer has no alternative but to make an arrest in order to protect the safety and welfare of the individual causing the disturbance and/or to ensure the safety and welfare of the general public. Many of the arrests involve individuals engaging in criminal activity that rises only to the level of a misdemeanor but due to a combination of factors, including the ongoing nature of the situation, the accused being unfit for arraignment, the accused's lack of residence and/or unavailability of a "safe drop off location," the arrestee is inevitably incarcerated. Once the individual is incarcerated, this triggers a heightened level of responsiveness from prison officials and defense counsel to identify, assess and plan what course of action should next be undertaken. Unfortunately, this process is inevitably cumbersome, slow and frustrating for all

involved due to a significant lack of resources, which leads me to the second part of my testimony.

The reality of the post-arrest/pre-trial phase involving an individual experiencing mental health issues and a lack of local resources typically translates to that individual being incarcerated for a period of time that exceeds the time period that a similarly situated non-mental health defendant will experience. This is primarily due, in my humble opinion, to two reasons. First, this County's MHID Department lacks the resources necessary to place within the county jail a full-time individual who is specifically trained to identify/diagnose the issue(s) at the time of intake, manage the individual's needs with a psychiatrist, manage meds and med compliance and work with the prison counselor to prevent the individual possibly being court ordered to Torrance State Hospital for further evaluation. Second, this County is in dire need of additional longterm care group home facilities that offer the structure needed for most individuals afflicted with mental health issues to thrive. It belies common sense to assume that returning individuals afflicted with mental health issues to the community (even if they become stabilized and/or med compliant while incarcerated) without equipping them with the appropriate resources to ease this transition is the most reasonably prudent course of action. Additional availability to local group homes as well as targeted case managers is a fundamental step in order to break the cyclical pattern of individuals afflicted with mental health issues regarding incarceration, release, incarceration, release and so on.

The measure of the increase in realized mental health cases presenting to the criminal justice system represents only a fraction of the total mental health cases within the county. Until and unless the financial resources of this Commonwealth are distributed to our rural community, this epidemic type situation will only continue to worsen as we can ill afford to alone bear the financial burdens.

Respectfully submitted,

Ryan C. Gardner
Lycoming County District Attorney

# Republican Policy Committee
# Addressing the Mental Health Needs of Rural Communities

**The Honorable Josh Kail, Chair**
**September 7, 2023**

Written Testimony of Sherry L. Shaffer
Chief Government Programs Officer, Chief Operating Officer
Community Care Behavioral Health Organization

Chairman Kail, Representative Flick, members of the Republican Policy Committee and distinguished guests:

Thank you for the opportunity to offer testimony today. My name is Sherry Shaffer and for the past 25 years, I have had the honor of working for Community Care Behavioral Health, serving our members and counties across Pennsylvania in the implementation of the Behavioral HealthChoices program. Community Care is a non-profit Behavioral Health Managed Care Organization Community (BHMCO) serving over one million Medicaid members in 43 Pennsylvania counties. In my current role, I have the privilege to partner with our primary contractors and local county human service systems, including Lycoming Clinton Joinder Board, in the implementation of their vision and goals for improving the health and wellness of their local citizens. Prior to joining Community Care in 1998, I spent the first 15 years working in leadership roles in human services organizations serving people with developmental disabilities, autism and mental health challenges.

Community Care's mission is to improve the health and well-being of the community through the delivery of effective, cost-efficient, and accessible behavioral health services. In collaboration with each of the counties we serve, our goal is to offer recovery-oriented, person-centered, accessible care that reflects current best practices in mental health and substance use disorder services.

The goal of Pennsylvania's HealthChoices Medicaid Behavioral Health Managed Care Program (HealthChoices) is to improve access to and the quality of mental health and substance use disorder care for Medicaid behavioral health services. The Pennsylvania model integrates Medicaid funded mental health and substance use disorder services into county-directed human services systems, offering opportunities to develop and integrate services to best meet the unique needs of our members, their families and the communities we all serve. Pennsylvania's integrated human services model, also referred to as the 'carve out', makes most sense in the context of meeting the needs of people living in rural communities.

**Expanding access to mental health and substance use disorder services**

Pennsylvania's integrated human services model has worked to expand access to quality behavioral health care by implementing evidence-based and best practices in services. Through Pennsylvania's integrated human services model, local county human service systems have worked with Community Care to develop and implement services to intervene early and connect people with mental health and/or substance use problems to local community-based treatment programs and supports to help people on their road to recovery and wellness. As a local example, West Branch Drug and Alcohol Commission implemented warm handoff programs with local emergency departments to intervene with people suffering from opiate addiction. This offers timely access to intensive support to help people engage in life saving medication assisted treatments and other recovery-oriented treatment services. Pennsylvania's integrated human services model has also worked to expand the continuum of mental health crisis intervention services by making investments in local behavioral health services to better meet the needs of local communities. Lycoming Clinton Joinder Board, for example, has been working to expand telephone, mobile and walk-in crisis services to better meet the needs of their local communities. Pennsylvania's integrated human services model is also uniquely positioned to help local counties, law enforcement and court systems to offer community-based treatment alternatives to incarceration for people with substance use and/or mental illness. As another example, Community Care has helped support Lycoming Clinton Joinder Board to implement trauma-informed care initiatives, in partnership with local behavioral health providers and court systems, to address the impact of traumatic experiences on our members, their families, providers and law enforcement professionals.

**Expanding Access to Mental Health Services for Children in Schools**

Through Pennsylvania's integrated human services model, Community Care has partnered with local county human service systems to develop and expand mental health treatment services in school settings. Mental health services in schools often include licensed outpatient providers, as well as student assistance programs and mental health case managers, who work together to assess the needs of students identified by school personnel and help get the student and their family connected to available services and supports, based on their individual needs. There are also more intensive, mobile services available to children who are eligible for Medicaid, which provide services to children in the home, school and community, based on the child and family's needs. By partnering with local human services leadership, school districts and mental health treatment providers, we have worked to expand the continuum of mental health services available to children and adolescents in schools. Our Community and School Based Behavioral Health (CSBBH) programs is an example of a program developed to better meet the unique needs of local communities. The CSBBH program provides flexible, school and community based services to youth with serious emotional challenges through teams of mental health professionals based in local school buildings. CSBBH mental health treatments, case

management and crisis intervention services are provided to youth in their home school, as well as to their families in the home and community. The CSBBH program has a demonstrated track record of improving youth and family functioning, reducing problem behaviors and improving prosocial behaviors of children in their home, school and community. School administrators also report a high degree of satisfaction with services and supports CSBBH teams provide to students in their schools.

As the need for mental health services for children in schools continues to grow, Community Care and our county human services partners are best positioned to meet new and emerging needs by working with local providers to expand and enhance the continuum of behavioral health services and supports available to our HealthChoices members and their families living in rural communities.

**Integrating Physical Health care for people with Behavioral Health conditions**

Pennsylvania's integrated human services model has also worked to address the medical health and wellness for people living with serious mental illnesses. Through Community Care's Behavioral Health Home Plus (BHHP) program, mental health case managers and peer support professionals are trained to screen for and recognize common medical conditions, coordinate care with medical professionals, educate their clients and provide wellness coaching to help people make lifestyle changes to address common health conditions, such as diabetes and hypertension. In partnership with local county human services leadership, we have worked with local behavioral healthcare providers to target and expand implementation of BHHP to insure people with mental illnesses are receiving the medical care they need and offering wellness coaching to help people make lifestyle changes to improve their overall health. The BHHP program has served over 10,000 individuals at over 65 locations across Pennsylvania, including in many rural communities across the 43 Pennsylvania counties we serve. Outcomes of the BHHP program includes a 36% increase in member utilization of primary and specialty medical care, while reducing overall healthcare costs by 15%. During 2022, the three BHHP providers in Lycoming Clinton achieved similarly positive outcomes for members served. The two BHHP providers based in mental health programs met goals for reducing blood pressure scores (85% of members demonstrated reduced blood pressure readings), screening for diabetes (over 90% of individuals screened) and reducing tobacco use among people served. In the opioid treatment BHHP program, 100% of people were screened for Hepatitis C, over 90% of people had an Annual Primary Care Physician (PCP) visit and 100% were screened using the 'Ask, Advise, Refer' intervention for Tobacco Use. Tobacco use screening and interventions to support people to reduce and stop tobacco use is also a key component of BHHP programs, with participating members reporting a 51% reduction in tobacco use. In Lycoming and Clinton counties, the two mental health program BHHP providers reported a similar reduction in tobacco use among 80% of people served. Given the success of the BHHP model in Lycoming Clinton counties, we expanded the BHHP program to two additional mental health providers in 2023, with plans to add a second drug and alcohol provider location in 2024. Community Care has also partnered with Lycoming Clinton counties to replicate the results of BHHP by offering

tobacco cessation trainings to local providers to expand the number of behavioral health providers offering treatments and interventions to reduce and eliminate tobacco use.

**Helping Address Basic Needs and Social Determinants of Health**

People experiencing mental health problems often have underlying, unmet needs such as unemployment, food insecurity, and difficulties finding affordable housing. Rural communities have also developed local resources for services and supports to individuals and families who need help meeting their basic needs. Pennsylvania's integrated human services model allows counties in partnership with their BHMCO to target additional resources to better serve the basic needs of local, rural community members.

Rural communities often have distinct challenges in accessing behavioral health services that are different than more urban areas. For example, rural communities often have more limited public transportation options and people have longer distances to travel to receive healthcare services. Affordable housing resources and employment opportunities also differ in and between rural communities. Local county human service systems are most familiar with their communities' needs and uniquely positioned to address them by integrating behavioral health managed Medicaid services with other county human services, supports and other local resources. As examples, local county human service systems offer early intervention services for young children and their families, as well as services and supports for older adults, children, youth and families and people with developmental disabilities. Local control offers counties the opportunity to develop services to meet the unique needs of their community members. This approach supports localized efforts that maximize cultural, demographic and regional strengths and resources.

**Addressing Behavioral Health Workforce Challenges**

The COVID Public Health Emergency exacerbated a decades long workforce shortage in the human services sector. While we have begun to see some recovery of losses in the direct services workforce in the mental health and substance use disorder services system, we need to implement both short and long term strategies to recruit and retain a workforce capable of meeting the growing needs for mental health and substance use services. Pennsylvania's integrated human services model allows local counties to make investments to help stabilize and grow the behavioral health workforce. As an example, Lycoming Clinton Joinder Board's HealthChoices leadership recently implemented a number of innovative programs to offer financial support to local mental health and substance use disorder providers to offer recruitment and retention bonuses to direct service workers, funding to help direct service staff obtain licensure and to purchase the technology needed to provide more mobile and telehealth services and supports for our members. Longer term strategies are needed to attract more

students to careers in behavioral health services, such as paid internships, tuition reimbursement and student loan forgiveness for young people who commit to working in public behavioral health and human services post-graduation.

For further information about the Pennsylvania integrated human services model, please refer to the two recent publications, attached for your reference:

- Leveraging the Strengths of the Behavioral HealthChoices Program to Support Integrated Care in Pennsylvania -published by the Center for Health Care Strategies
- Human Services and Behavioral Health Integration: A Model for Whole-Person Medicaid Managed Care - published by Psychiatric Services

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**South Williamsport Area School District**
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Dear State Policy Committee Members,

I would like to express my sincere gratitude for granting me the opportunity to address you today regarding the pressing matter of mental health issues, particularly those affecting students in our rural school districts. Your willingness to listen and engage in this critical conversation is a testament to your dedication to the well-being and future of our state's youth. As we collectively strive to create a more inclusive and supportive educational environment, your attentive ears and open minds are invaluable assets. With your continued support, we can work together to address the challenges faced by our rural students and pave the way for a brighter and mentally healthier future.

Rural school districts are unique in their composition, often grappling with limited resources, geographical isolation, and reduced access to specialized services. These factors contribute significantly to the mental health challenges faced by students in these areas. The disparity in mental health support between rural and urban districts is evident, and we must work together to bridge this gap.

The challenges faced by rural school districts are not unique to South Williamsport Area School District. As an educational system, it has become evident that society has relied more and more on us over the past few years to address these concerns for students and their families. The reality is this; we simply do not have the resources and are not trained to address the significant mental health needs our students face. Today, I will talk to you about five core issues that I believe rural school districts in the Commonwealth face around the issue of mental health, and I implore you to look for ways to enhance the level of support our social services systems can provide to school districts to help this insurmountable issue that school districts face.

**Limited Access to Mental Health Services:** In rural areas, there is often a scarcity of mental health professionals and facilities. Students who require counseling or therapy may have to travel long distances to access the necessary care, leading to potential disruptions in their academic progress. I would like to provide you a specific example of how this has impacted students in the South Williamsport School District. Since becoming the superintendent in South Williamsport, I have made it a priority to address the mental

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health needs of our students and families. I have attempted to create partnerships with our local social services agencies. I have met on multiple occasions with the staff at Community Care Behavioral Health and the leadership within the Lycoming/Clinton Joinder. Simply put, I have been trying to support our students with a Community and School-based Behavioral health program. This program teaches children new ways to manage their feelings and behaviors so the child is ready to learn and get along better with others. The team will help develop a treatment plan that is right for the child and make changes to the plan as needed. The team will work with the child, family and school officials to provide services that are flexible and meet the needs of the child and family. Regular progress reports are provided and parents/guardians will be involved in every part of the treatment. Services may include Individual Sessions, Group Sessions, Family Sessions, Case management, Behavior Management Planning, Crisis Intervention, and Referrals. This program, when implemented with fidelity, is a model program for partnerships between school districts and mental health agencies to support students and families within a school district. In my prior school district, I was able to see tremendous growth with students who participated in this year long program. When I attempted to start a program in Lycoming County, I was told that the need simply did not exist based on the way that the CCBH collected data for our students. In my opinion, they did not use a comprehensive approach to determine the level of need for the district. Creating a simple data system that more accurately reflects the mental health needs of my district is a barrier that rural school districts should not have to face. Simply put, we owe our students and parents better. We need stronger collaboration between school districts and agencies and we need to be innovative on how we partner. When we do not do this, students and their families suffer.

**Stigma and Awareness:** Stigmatization of mental health issues remains a concern in many rural communities. Lack of awareness and understanding can discourage students from seeking help, exacerbating their struggles and preventing early intervention. Unfortunately, the South Williamsport community has been stigmatized as a community where students not only have severe mental health needs, but bullying is an issue that is greater in our district than surrounding districts. Over the past 7 years, our school district community has had students and former students commit suicide. I believe you would agree. One suicide is one too many. This district, over the past two years has made a conscious effort to

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change that narrative. The district has put in place many programs for our students and staff to be proactively aware of the issues that our students bring to school each day.

We have entered a partnership with Panaroma to provide benchmark assessments to attain a deeper understanding of our student's mental health needs. At its core, the survey focuses on students' fundamental needs for motivation, social connectedness, and self-regulation as prerequisites for learning. From the benchmark data collection, the district analyzes the data and attempts to set up supports systems for students and families as they deal with struggles they identified through the survey. This past spring, we had 583 3rd – 12th grade students participate in our school climate survey to provide us insight on their perspectives of school. I am going to share with you a few statistics, both positive and negative, from the survey as it relates to mental health and school safety within our district:

- 81% of our students believe our teachers work hard to make sure ALL students are learning
- 85% of the students shared their school teachers do not allow students to give up when the work becomes too difficult
- 91% of the students felt their teachers expect everybody to work hard
- 83 % of our students reported feeling safe in the hallways, and 89% shared they feel safe in their classes
- 92% of the students reported they felt their teachers treated them with respect
- 70% of the students reported they believed that students are often teased and picked on by other students
- 43% of our students reported feeling threated or bullied by other students often
- 49% of the students reported that most of their peers struggle to get along with other peers
- Our students, when administered the Panorama survey, reported below the national average in self-regulation of emotions from grades 3rd-12th.

As a response to this, the district purchased and is currently implementing a research-based program called Second Step in grades kindergarten through sixth. The Second Step program helps students build social-emotional skills—like nurturing positive relationships, managing emotions, and setting goals—so

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they can thrive in school and in life. Topics covered include growth mindset and goal setting, emotional management, empathy and kindness, problem solving, and appropriate touch.

In November of 2022, the Pennsylvania General Assembly members from both chambers and both parties heralded the introduction of a mental health pilot program for public schools across the commonwealth called Kooth. Kooth, a web-based counseling program, was awarded a grant through the Department of Human Services that enables school districts to opt into the services without cost to students, parents, or the district. Kooth's innovative digital mental health and wellbeing platform has been designed to offer choice and encourage users to engage and seek help on their own terms. The service includes self-help content, anonymous safe, moderated forums, journaling, goal setting, and therapeutic activities. I am proud to share with you that the South Williamsport Area School District will be launching this program on September 13th.

**Educator Training:** Teachers and staff in rural schools often times are not adequately trained to recognize and address mental health concerns among students. Providing professional development to teachers around mental health is crucial for creating a supportive and nurturing learning environment for students. It becomes a challenge to provide quality support to our teachers who are on the "front lines" of supporting students with mental health needs daily. A prime example of our lack of education for future educators can be found through Commonwealth University, one of the state's highest producing teacher certification candidates for Pennsylvania. In order to complete an educator preparation program through Commonwealth University that does not include special education certification, future educators are only required to complete 9 credits in the area of special education to attain certification. While special education and mental health do not always go "hand in hand" the lack of preparation provided through coursework in teacher preparation programs is unacceptable and needs to be changed immediately. We must do better in our teacher preparation programs to educate our future teachers about the social and emotional well-beings of the students who walk into their classroom! But how do we provide current educators with quality support? First, I believe we must use a holistic approach. Mental health is interconnected with various aspects of an educator's role. We need to offer a training that covers topics such as identifying signs of distress in students, self-care strategies, fostering a positive classroom environment, and dealing with

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challenging behaviors. Invite mental health professionals, counselors, psychologists, and experienced educators to facilitate the training sessions. These experts can provide accurate information, practical tips, and real-world scenarios. Often times, in rural settings, it is a challenge to find qualified staff, and when looking to bring in regional and national level experts, the costs are always a challenge for school district budgets. Another dire staff need is to have a better understanding of trauma informed practices. Staff need to be equipped with a basic understanding of trauma-informed care. This will help them create a safe and supportive environment for students who may have experienced trauma. Finally, professional development in this area cannot be short workshops and one-time events. We must provide ongoing support and follow-up sessions to reinforce learning, address emerging challenges, and provide updates on best practices.

**Economic Hardship:** Rural communities often experience economic challenges, which can indirectly impact students' mental health. Financial instability in families can lead to stress and anxiety among students. Economic challenges in rural areas have a profound impact on the availability and accessibility of mental health resources within our schools. With high poverty rates and the exacerbated stressors for families, this places immense strain on children and adolescents. This financial strain not only limits access to basic necessities but also restricts access to mental health services, preventing students from receiving the support they desperately need.

Furthermore, the dearth of healthcare facilities and professionals in rural communities contributes to a significant lack of accessible mental health resources. Students are left grappling with feelings of isolation, exacerbated by limited access to counseling and therapy services. The digital divide only compounds the issue, making remote mental health support a distant dream for many students lacking reliable internet access. In turn, society continues to turn to the educational system to address the need that we are not fully equipped to address without innovative partnerships with mental health agencies and our local social service systems.

As we prioritize education in our state, we must acknowledge that optimal learning environments are only possible when students' mental health needs are met. I urge you to consider allocating resources to bolster mental health programs in rural schools, ensuring that students have access to timely and effective

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support. By investing in comprehensive mental health initiatives, including increased counseling services, training for educators, and awareness campaigns, we can foster a resilient generation of students capable of overcoming the unique challenges they face in rural communities.

I respectfully request your advocacy and support for legislation that prioritizes mental health resources in rural schools. By addressing this critical issue, we can empower our students to not only succeed academically but also thrive emotionally and mentally, ensuring a brighter future for our rural communities.

In closing, I would like to share with you an experience our school district had with a mental health agency where we attempted to partner to provide our students with school-based services. First, to be clear, I appreciate that we as a state have created stringent certification standards for our mental health professionals to provide quality services to our students and their families. While I believe the need for the standards does exist, inevitably it has discouraged many prospective future mental a health professional from pursuing the field because employment becomes a challenge without a master's degree and a rigorous and sometimes lengthy certification process, which can only be attained through the accumulation of large college debt. Each year, the district partners with a local mental health agency to provide support to students within the district. The level of support the child receives is dependent on the level of training of the counseling staff member. The worker that supported the students in our district through the local agency resigned to take on another position within the county, leaving us without a staff member. After the agency searched for a new employee for over two months, we finally were able to continue the services toward the end of the school year. Because the new counselor did not have the credentials needed to provide services to the over thirty students the prior counselor was serving, only seven of those students were able to continue to receive support under the new counselor. Furthermore, when questioned by myself on how long the credentialing would take for the new counselor, I was reminded it could take up to two years for the new staff member to receive the training. About twenty-five students who were eligible to receive services from the first counselor were no longer eligible to receive services, and furthermore, may have to wait as long as two calendar years to receive this support. This is the reality of the mental health supports in rural Pennsylvania.

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It is our responsibility to ensure that every student, regardless of their geographic location, has access to the mental health resources they need to thrive academically and emotionally. By addressing the mental health struggles faced by students in rural school districts, we can lay the foundation for a more resilient and prosperous future for our state.

Thank you for your time and consideration on this matter, and I look forward to potential legislative solutions to this ongoing issue. I believe that being united by a common purpose, we have the power to transform the mental health crisis into a catalyst for positive change. By fostering collaboration, compassion, and unwavering determination, we can illuminate the path toward a brighter, more resilient future for individuals, families, and communities alike.

# Human Services and Behavioral Health Integration: A Model for Whole-Person Medicaid Managed Care

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A comprehensive, whole-person approach to individuals' health care can be achieved by aligning, integrating, and coordinating health services with other human services. HealthChoices, Pennsylvania's managed Medicaid program, delegates responsibility for Medicaid-funded behavioral health service management to individual counties or multicounty collaboratives. County administrators' programmatic and fiscal oversight of Medicaid-funded services allows them to create synergies between behavioral health and other human service delivery systems and to set priorities on the basis of local needs. This model supports access to community-based care, integration of general medical and behavioral health services, and programs that address social determinants of health.

*Psychiatric Services 2023; 0:1–6; doi: 10.1176/appi.ps.20220478*

Discussions about Medicaid policy have recently focused on how to transition to a next generation of managed care that supports whole-person health. The challenges of the transition extend beyond simply integrating general medical and behavioral health services to include intersection with other systems (e.g., justice, child welfare), reducing health disparities, and attending to social determinants of health (e.g., poverty, housing instability, food insecurity). Faced with increased enrollment; spending growth; and high levels of behavioral, general medical, and social need within the Medicaid population, state policy makers confront a complex situation that likely requires programmatic innovation as well as payment reform (1).

HealthChoices, Pennsylvania's Medicaid managed care program, offers useful insights. Pennsylvania is the fifth most populous state, with approximately 13 million residents across 67 counties. Many of Pennsylvania's citizens live in the state's two largest cities and their counties: Philadelphia in Philadelphia County, population 1.60 million, and Pittsburgh in Allegheny County, population 1.25 million. According to the U.S. Census Bureau, 81.0% of Pennsylvania's citizens are White, 12.2% are Black or African American, 3.9% are Asian, and 8.4% are Hispanic or Latino (2). The median household income in 2020 dollars was $63,627, with 12.1% of the Pennsylvania population living in poverty (2). As of October 2022, more than 3.6 million Pennsylvania citizens were enrolled in Medicaid or the Children's Health Insurance Program (3).

Within the Pennsylvania HealthChoices program, general medical health plans for Medicaid members are known as Physical HealthChoices, behavioral health plans for Medicaid members are known as Behavioral HealthChoices, and Medicaid benefits for Medicare-Medicaid dual-eligible members are known as Community HealthChoices. For Physical HealthChoices and Community HealthChoices, the state contracts directly with managed care organizations (MCOs) to manage Medicaid recipients' medical care, pharmacy benefits, and long-term general medical services and supports. Behavioral HealthChoices, however, operates under a human services integration model that gives individual counties or multicounty collaboratives programmatic and fiscal responsibility for administering Medicaid-funded mental health and drug and alcohol services in addition to other human services (e.g., child welfare, aging services,

**HIGHLIGHTS**

- Medicaid policies that support whole-person health are critically important; county-level integration of Medicaid behavioral health services with the funding and leadership of other human services can effectively support these policies.
- Pennsylvania's HealthChoices behavioral health program offers a model for integrating human services with behavioral health services; this program expanded access to community behavioral health services, supported general medical and behavioral health service integration, and facilitated concurrent member engagement in programs that address social determinants of health.

housing services) in each county. In this model, a behavioral health MCO contracts with one or more counties or joinder counties (i.e., counties acting collaboratively as a single unit) to support counties' management of behavioral health services and collaborates with local provider networks, community-based human services agencies, and regional general medical health MCOs. Since the introduction of the human services integration–behavioral health MCO model in 1997, Pennsylvania has demonstrated progress in expanding access to high-quality behavioral health care, integrating general medical and behavioral health care delivery, and addressing social determinants of health, all while containing costs (4). These efforts are described next and summarized in Table 1.

## EXPANDING ACCESS TO HIGH-QUALITY BEHAVIORAL HEALTH CARE

Because Medicaid is the largest single payer for behavioral health services in the United States, ensuring access to high-quality behavioral health care is a priority. Many Medicaid beneficiaries with behavioral health conditions do not seek help through traditional avenues, even though they will be at risk for worse outcomes, higher overall health care costs, and more restrictive levels of care if their conditions are not addressed early (5). Under the human services integration–behavioral health MCO model, Pennsylvania counties leverage contractual ties linking behavioral health MCOs with other human services to coordinate services across county service networks. This approach allows individuals to enroll for both social and behavioral health benefits across a wide range of sites. Counties that meet contracted clinical and fiscal standards can, if they have excess funding for Medicaid behavioral health services in a specific year, reinvest up to 3% of revenues in developing or expanding local behavioral health services and related social supports. Local reinvestment plans that fill gaps in the existing service system, test new innovative treatment approaches, or develop cost-effective alternatives to traditional services promote continuous quality improvement. Because reinvestment decisions are made locally, these plans can be tailored to meet the needs of individual communities. For example, reinvestment funding has been used to expand or enhance mobile treatment teams, peer-driven recovery support centers, behavioral health nursing home transition and diversion services, school-based team services, and psychiatric rehabilitation.

County-level oversight of behavioral health service delivery enables meaningful local stakeholder engagement in identifying community needs and developing solutions for them. When families in rural Pennsylvania counties raised concerns about the adequacy of the children's behavioral health system in those counties, a multidisciplinary group of county mental health officials, family members, providers, behavioral health MCO leaders, and educators designed and implemented a novel model of services that facilitated close collaboration between schools and providers and allowed the same providers to treat children in both home and community settings. This collaborative effort, endorsed by school personnel, improved child and family functioning and reduced externalizing child behaviors, achieved high care satisfaction ratings, and led to strong therapeutic alliances (6). Achieving these outcomes was possible because of the integration of behavioral health MCO, school district, and county resources and oversight. Similarly, local partnerships among behavioral health, early intervention, and child welfare systems have supported innovations in measurement and clinical approaches (7) to address parental depression and early childhood development. Local partnerships also have supported the widescale implementation, sustainment, and expansion of trauma-informed care networks across 23 rural counties (https://bharpsystemofcare.org/trauma-resources).

Coordinated service delivery at the county level also supports effective development of necessary resources across the state. To address the opioid overdose epidemic, state and county governments, MCOs, and local provider networks launched initiatives to increase access to and continued engagement with evidence-based treatment and community-based care, including warm emergency department handoffs, telehealth prescribing, onsite bridging interventions, and improved substance use screening. For individuals receiving medication-assisted treatment, these efforts led to lower rates of benzodiazepine use and higher rates of concurrent behavioral health service utilization (8).

## INTEGRATING GENERAL MEDICAL AND BEHAVIORAL HEALTH SERVICES

Individuals with high behavioral health needs are more likely than others to have high general medical health needs. Co-occurring behavioral and general medical health conditions result in increased functional impairment and health care costs. The human services integration–behavioral health MCO model addresses these challenges at both practice and system levels. State and county agencies, MCOs, local providers, and other stakeholders have collaborated to implement a range of evidence-based integrated care practices, including screenings, engagement strategies, and shared care plans. This model supports provider networks that have partnered to promote integration through real-time information sharing, team-based care coordination, and joint approaches for assessing and rewarding high-quality care.

Numerous integrated care models now exist across the state. For example, general medical health caregivers are available in behavioral health settings; behavioral health clinicians offer services in primary care practices; and multidisciplinary primary care teams consisting of nurse navigators, wellness coaches, certified peer specialists, and certified recovery specialists are deployed. Many of these efforts have demonstrated positive clinical, quality, and cost outcomes. For example, implementation of the behavioral

**TABLE 1. Key challenges, strategies, lessons learned, and monitoring metrics for the integration of human services with behavioral health services in Pennsylvania**

| Key challenges | Strategies | Lessons learned | Monitoring metrics |
|---|---|---|---|
| Expanding access to community behavioral health care | Collaborated with key stakeholders to secure federal or other funds (e.g., HRSA, PCORI, SAMHSA)[a] to supplement state resources; leveraged funding from multiple sources to increase use of medication-assisted treatment for opioid use disorder in community settings; engaged primary care physicians to treat individuals with opioid use disorder, with support from regional centers of excellence; developed value-based payment plans to incentivize use of medication-assisted treatment for opioid use disorder | County participation in prioritizing and supporting community-based behavioral health care is critical to success; ambulatory care is the backbone of a strong behavioral health delivery system, so continuing to strengthen and offer innovative ambulatory care should be prioritized; despite increased access to medication-assisted treatment, the statewide opioid use disorder death rate increased over a recent 24-month period (2019–2021), although this increase has been less than that of other states; the organizational structure and culture of most primary care practices do not support team-based treatment of opioid use disorder; disparities remain in medication-assisted treatment prescribing | Resource targeting (under Behavioral HealthChoices, more resources are spent on ambulatory services than on inpatient and residential services); number of Community Care members receiving medication-assisted treatment (increased 43% from January 1, 2018 [N=22,047], to June 30, 2022 [N=31,569]); total number of Community Care members receiving center-of-excellence services (cumulative N=16,136 from July 1, 2019—when Behavioral HealthChoices began payments for centers of excellence—to September 30, 2022); total number of agencies providing center-of-excellence services (>50 from July 1, 2019, to September 30, 2022) |
| Integrating general medical health and behavioral health | Integrated general medical health professionals into behavioral health care settings to establish behavioral health homes as part of recovery for individuals with serious mental illness; implemented collaborative care approaches in primary care settings and Federally Qualified Health Centers; provided training and other supports to behavioral health professionals colocated in primary care settings; incentivized integration at multiple levels (individual and system) via a pay-for-performance integrated care program supported by general medical and behavioral health managed care organizations | Behavioral health homes can enhance engagement in treatment and increase utilization of primary and specialty medical care; case managers and peers can serve as effective health navigators with appropriate training and modest nursing resources; a modest investment of resources in nursing support has a significant financial return and clinical impact; effective change requires a continuous quality improvement process and ongoing technical assistance; collaborative care codes are often not sufficient to support care outside Federally Qualified Health Centers; colocation can be successful in larger health systems but remains challenging in smaller systems | Impact of behavioral health homes on engagement in primary and specialty care (significant increases over a 2-year period, from a mean of 7.6 visits to 10.3 visits) (9); effect of behavioral health homes on cost and utilization (15% reduction in total cost and 43% increase in use of outpatient general medical services) (10); effect of behavioral health homes on important health behaviors (positively affected screening and intervention for tobacco use and hypertension, among other conditions) (11) |

*continued*

**TABLE 1,** *continued*

| Key challenges | Strategies | Lessons learned | Monitoring metrics |
|---|---|---|---|
| Addressing social determinants of health | Instituted routine screenings for social determinants of health by behavioral health managed care organization care managers; offered employment and vocational programs to Behavioral HealthChoices members; promoted supportive housing programs through reinvestment from capitated revenues at the county level; supported community-based partnerships to address social determinants of health through contractual requirements and with state funding | Screening for social determinants of health as a care management strategy is critical; housing is key to addressing social determinants of health, and braided payment models are needed to support housing stability; funded clinical housing has been successful but limited because of funding requirements and scarce resources for housing investments | Effect of social determinants of health care management intervention (compared with treatment as usual, the intervention was associated with fewer readmissions to substance use disorder facilities and better follow-up to aftercare) (14) |

[a] HRSA, Health Resources and Services Administration; PCORI, Patient-Centered Outcomes Research Institute; SAMHSA, Substance Abuse and Mental Health Services Administration.

health home plus model, which addresses general medical health and wellness as part of recovery for individuals living with serious mental illness (e.g., schizophrenia, bipolar disorder, major depressive disorder), resulted in improved patient activation and engagement in care, increases in primary and specialty medical care visits and outpatient services, and reductions in inpatient treatment utilization and overall cost (9, 10). Behavioral health home plus providers have also improved screening and intervention for tobacco use, hypertension, and diabetes through engaging individuals in wellness coaching (11). Today, this model is offered at 65 behavioral health provider sites across Pennsylvania that serve over 10,000 individuals each year. Many behavioral health home plus model components are also applied in residential and outpatient substance use treatment facilities statewide.

Behavioral health MCOs, general medical health MCOs, and local providers have also undertaken pharmacotherapy initiatives to ensure behavioral health medications are used appropriately in the treatment of both children and adults (12). These initiatives include activities that promote metabolic monitoring for people on antipsychotic medications and improve the medication adherence of people discharged from inpatient psychiatric hospitalization (13).

As a result of these efforts, Pennsylvania ranks in the top quartile of states nationally on quality measures that rely on coordination of general medical and behavioral health, such as diabetes screening and medication adherence for persons with schizophrenia and the limited use of multiple antipsychotics among children and youths with serious emotional and behavioral conditions. Additional assessments substantiate the ability of HealthChoices behavioral health MCOs and general medical health MCOs to work together in the pursuit of positive health outcomes for Medicaid recipients (4, 9).

## ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have been identified as factors affecting health care access, clinical outcomes, and health care costs and are of increasing interest to Medicaid policy makers. Given the high prevalence and acuity of behavioral health issues in the Medicaid population, states are exploring strategies to address social determinants of health in health care delivery, such as using Medicaid section 1115 waivers to cover certain nonmedical services, requiring MCOs to connect Medicaid recipients with social supports, and adopting value-based payments to support social services interventions.

The human services integration–behavioral health MCO model enables Pennsylvania counties to address gaps in the social safety net for Medicaid recipients. Through contractual ties and by blending county, state, and federal funding streams, county human services agencies can facilitate the integration of traditional and nontraditional services and supports to assist community members in need. County agencies can provide support for a range of basic needs (e.g., supplemental nutrition, utility and cash assistance, supportive housing, education and employment opportunities, transportation) and connect Medicaid enrollees to cross-sector resources (e.g., child welfare agencies, aging services, intellectual and developmental disability supports, early intervention services, veterans' services, legal and justice agencies, school districts). Similarly, one behavioral health MCO, working collaboratively with counties, developed an intervention that directly addressed social determinants of

health when Medicaid enrollees were in a hospital or rehabilitation setting; compared with treatment as usual, the intervention was associated with fewer readmissions to substance use disorder facilities and better follow-up to aftercare (14). In 2021, Pennsylvania enacted contractual managed care requirements and funding to support community-based partnerships, leading to comprehensive planning around individuals' basic and human service needs. Counties also receive money directly from the state to pay for services not covered by Medicaid, such as housing, employment, vocational supports, child care, nutrition, and transportation. County oversight of multiple funding streams allows community leaders to allocate funding in the best interests of their constituents.

Pennsylvania counties have also used reinvestment funds to expand or develop new programs to address social determinants of health for constituents with mental health conditions. One urban county reinvested over $17 million into supportive housing programs for youths transitioning from child welfare, juvenile justice, or mental health housing to independent apartment living. Another initiative expanded permanent supportive housing for adults with serious mental illness at risk for long-term institutional care and offered budgeting, home maintenance, landlord communication, short-term financial aid, and housing choice voucher (Section 8) application assistance services.

## CONTAINING COSTS

Pennsylvania's focus on integrating health and human services at the county level has led to an overall shift from more expensive and more restrictive inpatient care to less expensive and less restrictive community-based care, such as mobile treatment and peer support (4). This shift, supported by the stabilization and enhancement of the behavioral health workforce, has produced cost savings by decreasing the total cost of care and inpatient spending (4). Indeed, although the price of services has increased, cost savings have still been realized. For example, over a recent 10-year period (2011–2021), the national Consumer Price Index increased 3.1% annually for health services (15). During that same time, per capita spending for Medicaid-funded behavioral health services decreased 0.7% annually in 41 Pennsylvania counties (Community Care Behavioral Health Organization, 2021, unpublished data). Despite concerns that carve-out models lead to higher administrative costs, the human services integration–behavioral health MCO model has maintained administrative expenses as a percentage of revenue at the same levels incurred by general medical health MCOs (4).

## NAVIGATING THE ROAD AHEAD

Pennsylvania's experience offers reason for optimism that effective whole-person care and cost containment can coexist in a Medicaid behavioral health managed care program. In fact, from 2019 through 2022, Mental Health America ranked Pennsylvania among the top eight states for addressing mental health and substance use (https://mhanational.org/issues/2022/ranking-states). This high ranking—based on national survey data measuring communities' mental health needs, access to care, and treatment outcomes—likely occurred in part because of the success of Behavioral HealthChoices. If the integration of human services and behavioral health services is prioritized, then a coordinated approach to service delivery, meaningful stakeholder engagement, and opportunities for local reinvestment can follow, resulting in positive outcomes for states, communities, and Medicaid beneficiaries.

The human services integration–behavioral health MCO model works well in Pennsylvania because the state government delegates many social services interventions to individual counties. This approach supports localized efforts that maximize cultural, demographic, and regional strengths and resources. Although the human services integration–behavioral health MCO model may not be a good fit for other states, related efforts focused on standardizing requirements for high-quality integrated service delivery and outcomes, building connections between behavioral health and human services agencies to enhance access and address social needs, and promoting integrated care approaches may offer opportunities for improvement.

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The authors gratefully acknowledge the contributions of our state and county partners. They also appreciate the time and effort of Amanda Maise, M.S.P.H., who carefully proofread and edited the manuscript before submission.

These views represent the opinions of the authors and not necessarily those of UPMC Insurance Services Division.

Dr. Neimark owns stock in Pfizer, Plandaí Biotechnology, and Tonix Pharmaceuticals. The other authors report no financial relationships with commercial interests.

Received September 19, 2022; revision received November 21, 2022; accepted December 19, 2022; published online March 20, 2023.

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Center for Health Care Strategies

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

**APRIL 2023**

By Logan Kelly and Allison Hamblin, Center for Health Care Strategies

*Made possible by the County Commissioners Association of Pennsylvania, County Managed Care Resource (COMCARE).*

# Contents



## ACKNOWLEDGEMENTS

The authors would like to thank leaders from the following organizations for participating in interviews to inform this report: Capital Area Behavioral Health Collaborative and PerformCare; Erie County Department of Human Services and Community Care Behavioral Health; Montgomery County Department of Health & Human Services and Magellan Behavioral Health of Pennsylvania; and Philadelphia Department of Behavioral Health and Intellectual disAbility Services and Community Behavioral Health.

## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

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*This report was made possible by the County Commissioners Association of Pennsylvania, County Managed Care Resource (COMCARE). The opinions expressed are those of the authors at the Center for Health Care Strategies and are not necessarily the same as those of the County Commissioners Association of Pennsylvania.*

# 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.

**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.**

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.

# 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 for 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.

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### 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.

## ENDNOTES

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