General Assembly of the Commonwealth of Pennsylvania
Joint State Government Commission
Room 108 Finance Building, 613 North Street
Harrisburg, PA 17120
717-787-4397

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Short summary in response to 2022 Senate Resolution 352
Medical Assistance Capitation Funding for
Drug and Alcohol Treatment Providers within the Commonwealth

SR352 directed the Commission to collect information on data and mechanisms that determine capitation funding paid to Pennsylvania's drug and alcohol treatment providers. Specifically, the resolution asked for an explanation of the process used to distribute funding from the Department of Human Services (DHS) to counties and from counties to Behavioral HealthChoices Managed Care Organizations (BH-MCOs). Additionally, the resolution asked for information on DHS' cost-reporting system for capitation rates and factors included in calculations. Similar information was requested from Single County Authorities (SCAs). The resolution also asked for information about expenses, policies, and mechanisms related to BH-MCOs rate negotiations.

Pennsylvania's system of public funding for drug and alcohol treatment is administered through two separate sources: DHS funding based on a managed care model for those on Medical Assistance through Behavioral HealthChoices and Department of Drug and Alcohol Programs (DDAP) funding for treatment for those who are uninsured or underinsured. The focus of this report is the managed care model, specifically the BH-MCOs.

Through many interviews with stakeholders at all levels of the funding mechanisms, Commission staff developed five recommendations. First, there is a lack of publicly available information on how these programs are administered, leading to confusion or even disillusion with the system from some providers. The process for developing reimbursement rates should be made more transparent. Second, different contractors and BH-MCOs require different financial information from providers, leading to an additional administrative burden for providers when requesting increased rates. Providers should be properly trained to submit financial information. Third, the HealthChoices contracts include many eligibility requirements for providers to participate in the programs, but do not place accountability on BH-MCOs to ensure that providers receive a fair reimbursement rate. BH-MCOs must have a rate increase request policy but are not required to reveal the specific information they consider in a rate review or explain a denial for an increase to a provider. BH-MCOs should give providers explanations for rate increase denials or counteroffers. Fourth, similarly, SCAs do not seem to be required to justify denials or counteroffers to providers' XYZ Packages. SCAs should give providers explanations for rate increase denials or counteroffers. The last recommendation is that funding opportunities and incentives offered to providers should focus on sustainable rate increases instead of inconsistent lump sums, which cannot be budgeted for year over year.

The full report is available on our website.

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