JOURney COURse

OUR PATH THROUGH CHALLENGES AND CHANGE

July 2019-December 2020

Annual Report of the Steering Committee to the Board of Directors

Tuscarora Managed Care Alliance

My View

A MESSAGE FROM THE EXECUTIVE DIRECTOR

To say the last 18 months was challenging may be the greatest understatement of my career. The varied and unfamiliar terrain of planned changes and unplanned challenges tested not only abilities of TMCA Staff but the responsiveness, resourcefulness and ingenuity of the Medicaid Behavioral HealthChoices system across Franklin and Fulton Counties.

The obvious first challenge is the change occurring from a DHS Agreement Amendment transitioning our program from a fiscal year reporting cycle to a calendar year reporting cycle. This created an 18-month reporting period to transition to the calendar year which changed this year's annual reporting interval.

Within the same amendment, DHS initiated a changing payment frequency which would result in a capitation payment delay of 3 months from April to July. With careful modeling and planning, TMCA was able to maintain the required restricted reserves to continue to be a Risk Assuming Non Licensed Insurer Preferred Provider Organization in PA and did not require financing to maintain a positive cash flow.

The months of September 2019 through February 2020 progressed at a familiar pace. TMCA and PerformCare, our Behavioral Health Managed Care Partner, focused on implementation of the Community HealthChoices, which is the DHS Managed Care Program for individuals that are dually eligible for Medicaid and Medicare. We continued to refine our Physical Health and Behavioral Health coordination efforts for members with co-morbidities, continued to develop our value based purchasing initiatives including the implementation of our first moderate risk model with Family Based Mental Health providers and we even hosted our first large scale Community Event, One Laugh At a Time, a Celebration of Recovery with comedian Kurtis Mathews. We were well on our way to planning for the transition and implementation from Behavioral Health Rehabilitation Services to Intensive Behavioral Health Services by the early months of 2020. Providers were receiving education and training to prepare for the newly created licensing process to become a provider of IBHS. TMCA staff and PerformCare were participating on workgroups with OMHSAS to provider clarification surrounding the new regulations.

In mid-March 2020, just as we were hitting our stride, the Covid 19 virus disrupted everything. On March 17th, OMHSAS held the first of many COVID 19 web conferences to put into place waivers of regulatory requirements and safety procedures for Providers and Medicaid Members. The COVID 19 virtual meetings and evolving responses continued on a regular basis throughout the remainder of 2020.

...CONTINUED

By March 23rd, TMCA staff moved from a physical site workplace to a remote work status 5 days per week and continued to do so until early September 2020. Staff's limited return to on-site was short lived as by the week of Thanksgiving a second surge of the virus started to peak and staff returned to full remote operations through the end of 2020. Needless to say, communication via virtual means increased to an unprecedented level with OMHSAS, PerformCare and our Provider network.

First and foremost the safety of Provider Staff and Medicaid Members become the focus of TMCA and PerformCare. While maintaining the safety net, in person services, providers started the transition to virtual service delivery for routine and non-urgent/emergent needs through audio visual platforms. For Medicaid Members that did not have access to technology and equipment, providers created staffing and office safety plans for in-person services. TMCA shared evolving COVID safety procedures and distributed OMHSAS and CMS related regulatory guidance with providers frequently. Additionally, resources related to low-cost phone and internet for low income individuals were shared along with resources to meet the food, clothing and shelter needs of individuals that may be displaced or at risk due to the pandemic. Far exceeding expectations, several providers delivered food to members that were immunocompromised or in quarantine and assisted members and families in accessing devices and internet services to participate in telehealth services.

Our second focus was to ensure our critical local and statewide behavioral health providers remained fiscally stable during the pandemic and would be able to meet the pre-pandemic service demands once the state of emergency ended. TMCA and PerformCare mobilized to craft alternative payment arrangements moving from a Fee- For -Service environment to a prospective monthly payment based on historical utilization. Analysis revealed that local ambulatory providers of Mental Health and Substance Abuse Outpatient, Partial Hospitalization, Peer Support, Targeted Case Management, Family Based Mental Health Services and Behavioral Health Rehabilitative Services would potentially require reimbursement assistance to sustain workforce and operations through the pandemic. Providers encountered difficulty delivering services at the previous volume due to restrictions regarding home and community service delivery. To compound these issues, providers had increased expenses related to hardware and software for audio visual service delivery; employee leave due to quarantine and Covid 19 illness; and increased costs in physical office and staff personal protective equipment. Ambulatory Providers were invited to participate in the APA. As a condition of inclusion, providers would submit monthly financial reports related to COVID related expenses, meet with TMCA monthly and pledge to retain staffing at the same pre-pandemic level.

TMCA did a similar analysis related to 24/7 operating facility-based treatment providers to determine which sites were critical to our network and future needs. These providers would receive a gap payment for the difference of average historical utilization and the current period actual utilization. We determined that providers in these categories were Non Hospital Based Drug and Alcohol Facilities and Mental Health Children's Inpatient Facilities.

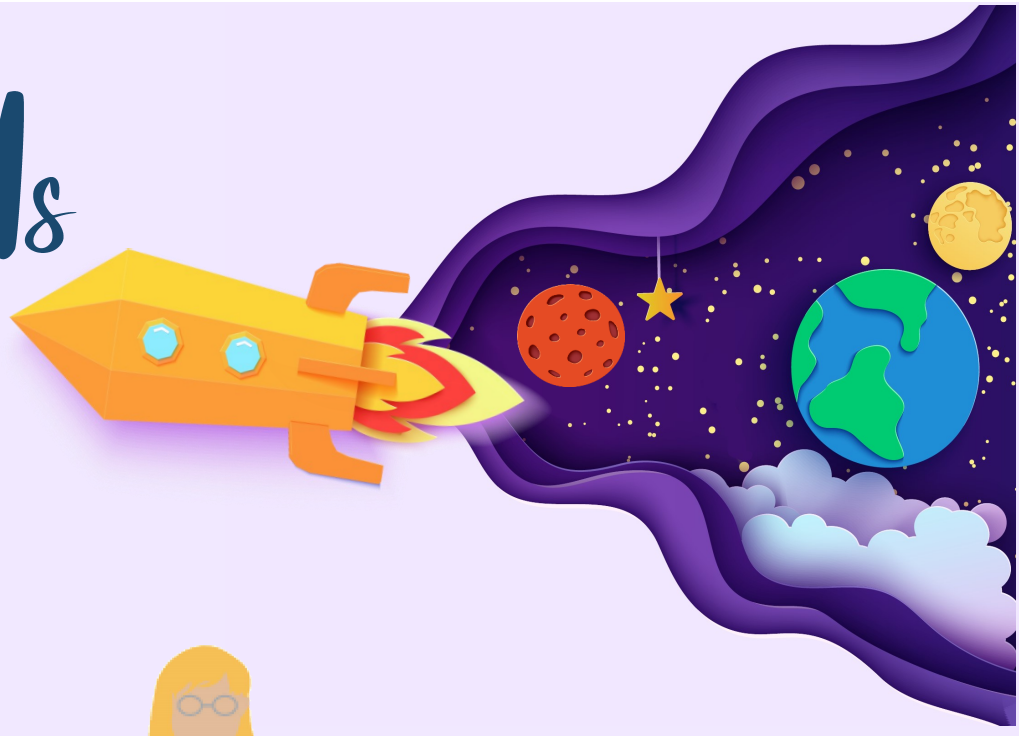
Throughout the pandemic TMCA staff monitored COVID 19 community positivity rates and met with providers, both in group settings and individually, on a monthly basis. By June community positivity rates were decreasing and providers were becoming better educated and equipped to start transitioning to in person services on a limited basis. Most providers had developed protocols to ensure staff and member safety in addition to using creative strategies to reduce COVID 19 risk. In-home service providers did pre-visit symptom screening of families and conducted sessions outdoors or in open sheltered spaces. Some providers did a hybrid mix of telehealth and in person services on a rotating basis to minimize exposure from frequent contact yet remained connected with members in person to reduce the risk of isolation in high risk individuals and families. In-person service delivery increased steadily with sessions resuming back towards pre-pandemic levels by the end of September 2020.

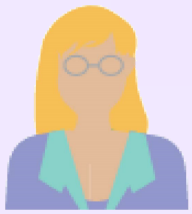
As the late fall and early winter arrived, so did the increase in positivity rates which in turn limited the ability to conduct in person sessions in open environments. Provider's responses became fluid and adept relying on social distancing and screening practices and using the flexibility of telehealth in community and outpatient settings. While inpatient providers began to use co-horting strategies; relying on PCR testing before and during facility based stays; and reducing capacity to aid in social distancing.

Overall, having never encountered a public health emergency as pervasive as the COVID 19 pandemic, I have been honored and humbled by the ingenuity, fluidity and commitment of our behavioral health system. While the pandemic still looms ahead in the upcoming year, I have no doubt in the abilities of our providers to meet the varying transitions, demands and needs of individuals needing behavioral health services in Franklin and Fulton Counties.

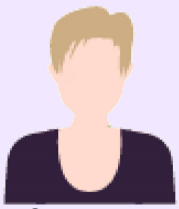
Thank you,

This is Us





Melissa Reisinger
Executive Director

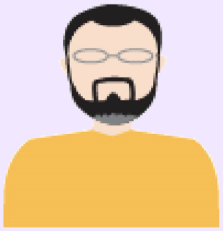


Gen Harper
Quality & Compliance Director

Jessica Allen
Office Manager

Kathy Doyle-Lehman
Finance Director

Jessica Brangaccio
Planning & Development Director

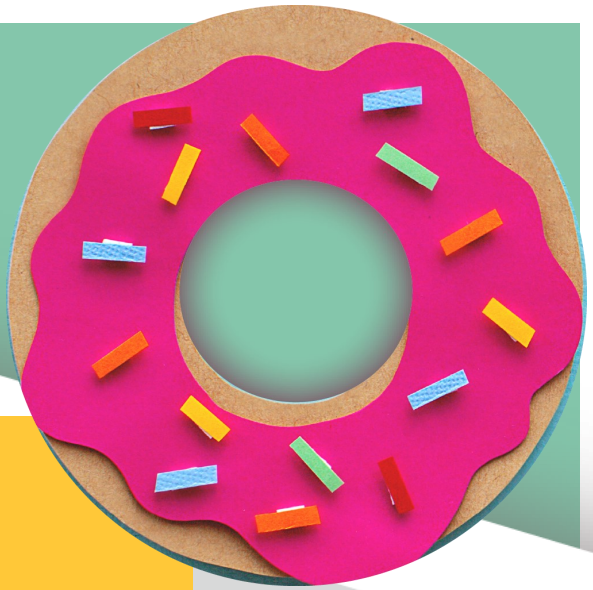


Brad Coccagna
Quality Specialist

OUR STAFF ARE OUT OF THIS WORLD!

Thomas Hippenstiel
Data Engineer

Our Guidance



STEERING COMMITEE

Sheldon Schwartz, Chair
Franklin County Community Member

Julia Dovey, Vice Chair
Fulton Family Partnership

David Keller
Franklin County Commissioner

Christine McQuade
Fulton County Services for Children

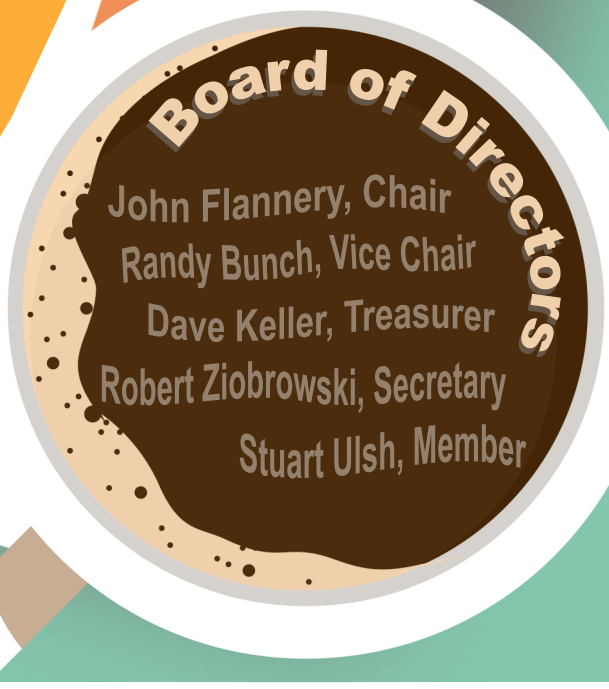
Christy Unger
Franklin/Fulton Drug & Alcohol Program

Stacie Horvath
Franklin County Human Services Administration

Stacey Brookens
Franklin/Fulton MH/IDD/EI Department

Teresa Beckner
Franklin County Fiscal Department

Paula Shives
Fulton County Commissioner



Demographics

ADULT CONSUMERS	
Inpatient Mental Health	319
Outpatient Mental Health	4,575
Outpatient Drug & Alcohol	1,151
Inpatient Drug & Alcohol	439
Crisis Intervention	529
Targeted MH Case Management	512
Peer Support Services	142
GRAND TOTAL	**5,478**

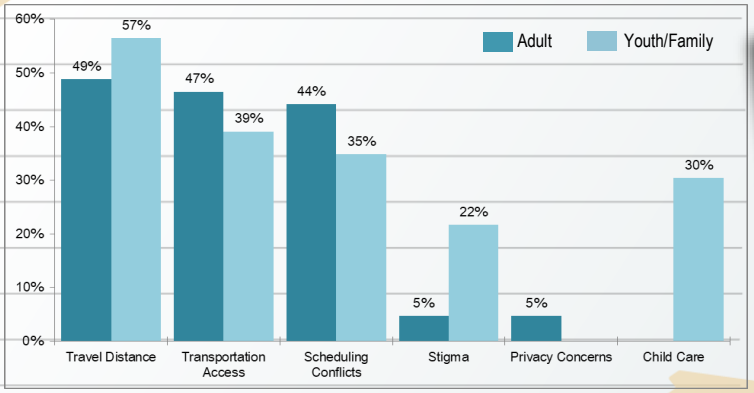
CHILD/ADOLESCENT CONSUMERS	
Inpatient Mental Health	108
Outpatient Mental Health	2,765
Outpatient Drug & Alcohol	27
Inpatient Drug & Alcohol	15
Crisis Intervention	265
Targeted MH Case Management	265
Behavioral Health Rehab. Services	458
Residential Treatment Facility	47
Family-Based Mental Health	239
Psychiatric Partial Hospital	9
GRAND TOTAL	**3,015**

PENETRATION RATE: TWENTY-ONE PERCENT OF MEMBERS RECEIVED A SERVICE.

Impact of Covid Pandemic

TELEHEALTH SERVICES

Identified Challenges Eliminated Through Telehealth



76%

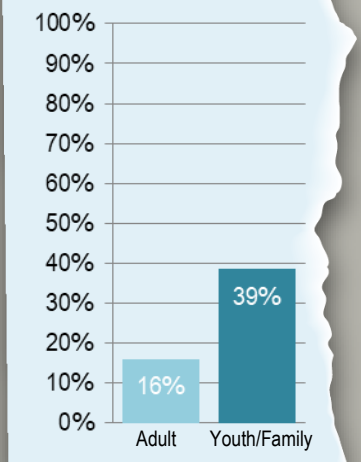
OF SURVEYED INDIVIDUALS REPORTED FEWER RESCHEDULED AND CANCELED APPOINTMENTS UTILIZING TELEHEALTH.

The impacts on the Mental Health Service Delivery and Licensing during the pandemic had highs and lows. For a large portion of 2020, annual license visits became desk reviews with a virtual interview. For some providers, it simply meant providing OMHSAS with temporary access to their Electronic Health Records. For providers without that capability, it meant photocopying or scanning hundreds of pages of records to be sent via mail, or electronically. Despite the challenge, OMHSAS reported all providers were able to be reviewed and only a few had difficulties in gathering the necessary information.

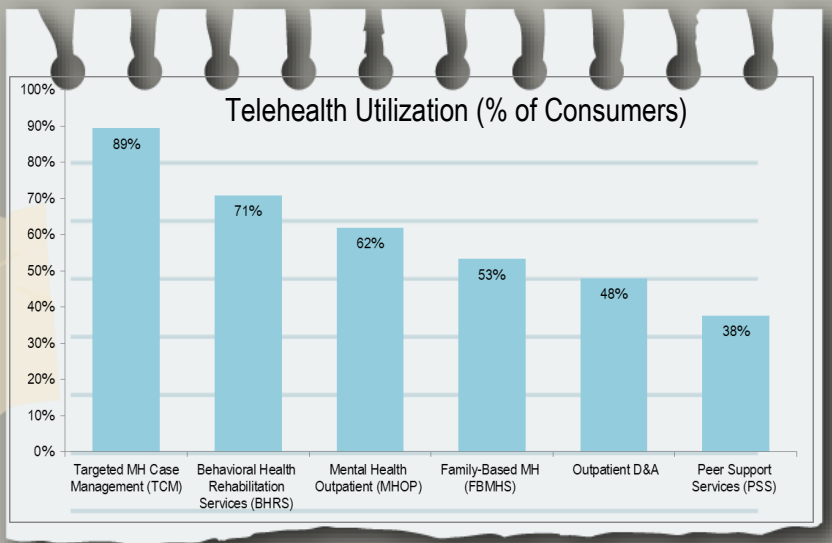
Providers of community based services were faced with unprecedented challenges and in many cases rose to the challenge with vigor and creativity. After a quick response from OMHSAS, a bulletin allowed for the billing of telehealth and a scramble across the continuum of care began to get members access to the services they needed. Many of the Mental Health Outpatient providers were already providing telehealth for psychiatric services and were able to adapt quickly to adding therapy via the telehealth method. For those services that are more intensive and require home and community visits, Providers implemented safety protocols that allowed face-to-face to continue, such as purchasing camp chairs and pop-up canopies for outdoor sessions. Porches and backyards became the living rooms.

In some cases, individuals who needed to "see" their provider did so from their cars in a parking lot, windows down, masks on. One Substance Use Outpatient Provider set up a live stream of group therapy so that half the group could be in person and half could be at home participating virtually. This greatly increased capacity of services and allowed flexibility for members.

Individuals Who Reported Barriers in Accessing Telehealth



Telehealth Utilization (% of Consumers)

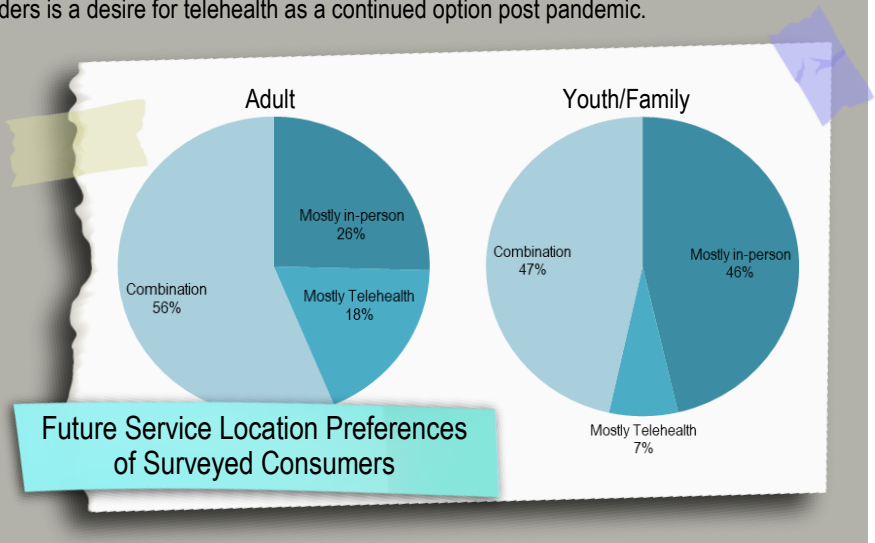


Impact of Covid Pandemic

...TELEHEALTH CONTINUED

As the year and the pandemic progressed, OMHSAS requested that Primary Contractors survey members on the use of telehealth. A survey was developed by OMHSAS and our Consumer Family Satisfaction Team conducted the surveys. The team was able to collect 110 surveys of adults, families and youth (5.9% of sample population) who had received a MH service via telehealth. Those results were reported back to OMHSAS and shared with our network.

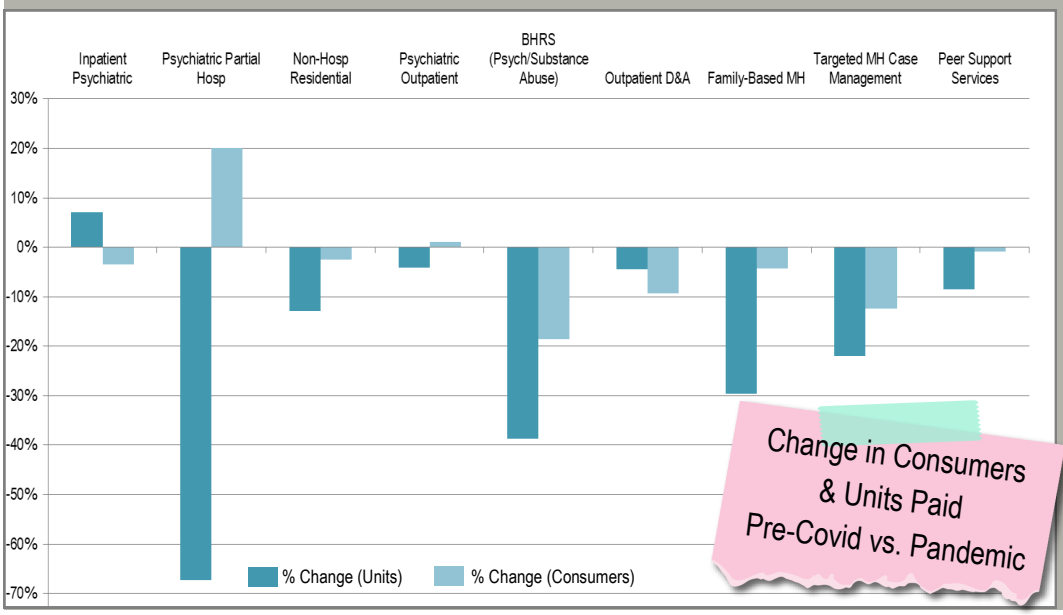
It's important to note that even though telehealth services became a primary mode of delivery, the vast majority of our community-based providers continued to offer in-person services. Newly written office safety protocols and face-to-face policies and procedures allowed providers to have members safely receiving services. The future of telehealth is not finalized, but the overwhelming consensus from consumers and providers is a desire for telehealth as a continued option post pandemic.



Future Service Location Preferences of Surveyed Consumers

ALTERNATIVE PAYMENT ARRANGEMENT

As a result of the COVID 19, TMCA and OMHSAS immediately recognized the need to ensure that behavioral health providers remained financially viable during the pandemic. The duration, impact on service delivery, and effects on public behavioral health were uncertain in the beginning.



Change in Consumers & Units Paid Pre-Covid vs. Pandemic

We wanted to ensure that our provider network would be able to continue responding to behavioral health needs and supporting individuals during this time of social isolation and increased stress. Additionally, we wanted to ensure the size of the current workforce would be able to meet the pre-pandemic service demands once the state of emergency ended.

TMCA crafted an alternative payment arrangement for critical local ambulatory providers to ensure that they maintained baseline funding and staffing while covering the extra expenses needed to supply personal protective equipment, heighten cleaning/disinfecting processes and purchase or upgrade platforms for delivering telehealth services.

Impact of Covid Pandemic

...APA CONTINUED

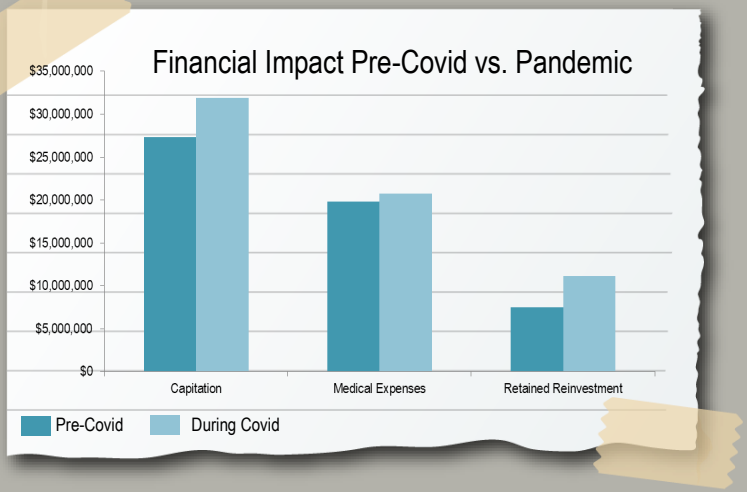
Select providers were offered a monthly prospective payment based upon historical claims trend. A provider's payment was conditional upon continued submission of personal level encounter data, monthly expense reporting, retaining current staffing and monthly meetings with TMCA and PerformCare to discuss any emerging trends, needs or obstacles in operations.

TMCA also identified service types that were not geographically close but critical to ensuring treatment options and access. The critical services were identified as Mental Health Inpatient (Adult and Child) and Substance Abuse Non-Hospital Rehabilitation. TMCA then determined which providers of these two service types served the majority of members accessing treatment in the previous 18 months. During the pandemic, TMCA monitored utilization of these service types/levels and retrospectively provided a gap payment for the difference between current units of service and monthly historical average units of service.

The APA arrangement was discontinued for Outpatient Mental Health and Outpatient Substance Abuse on October 31, 2020. TMCA instituted a rate increase of 4% to account for any COVID 19 related variations of service delivery. Both of these service levels were able to adapt relatively quickly to the changing circumstances of the pandemic due to the frequency of contact of the service and telehealth technology. When comparing calendar year 2019 to calendar year 2020, MH Outpatient increased the number of members served in 2020 by 1% and had a 4% reduction in the units of service delivered. In the same time period, Substance Abuse Outpatient had a 9% reduction in the unique members served but only had a 4.4% reduction in the units of service delivered.

The APA arrangement for all other levels of care continued throughout the remainder of the contract year due to COVID 19 impacts on the ability to deliver in-home, community-based and 24/7 facility-based care. Each of these levels of care experienced significant reductions in billable units of service from historical production rates.

Additionally, the APA also enabled TMCA to retain Pre-Covid Percentage of claims allocations.



From March through December, 2020, HealthChoices Eligibles have increased on average of 493 members per month as a result of the Covid-19 Pandemic.

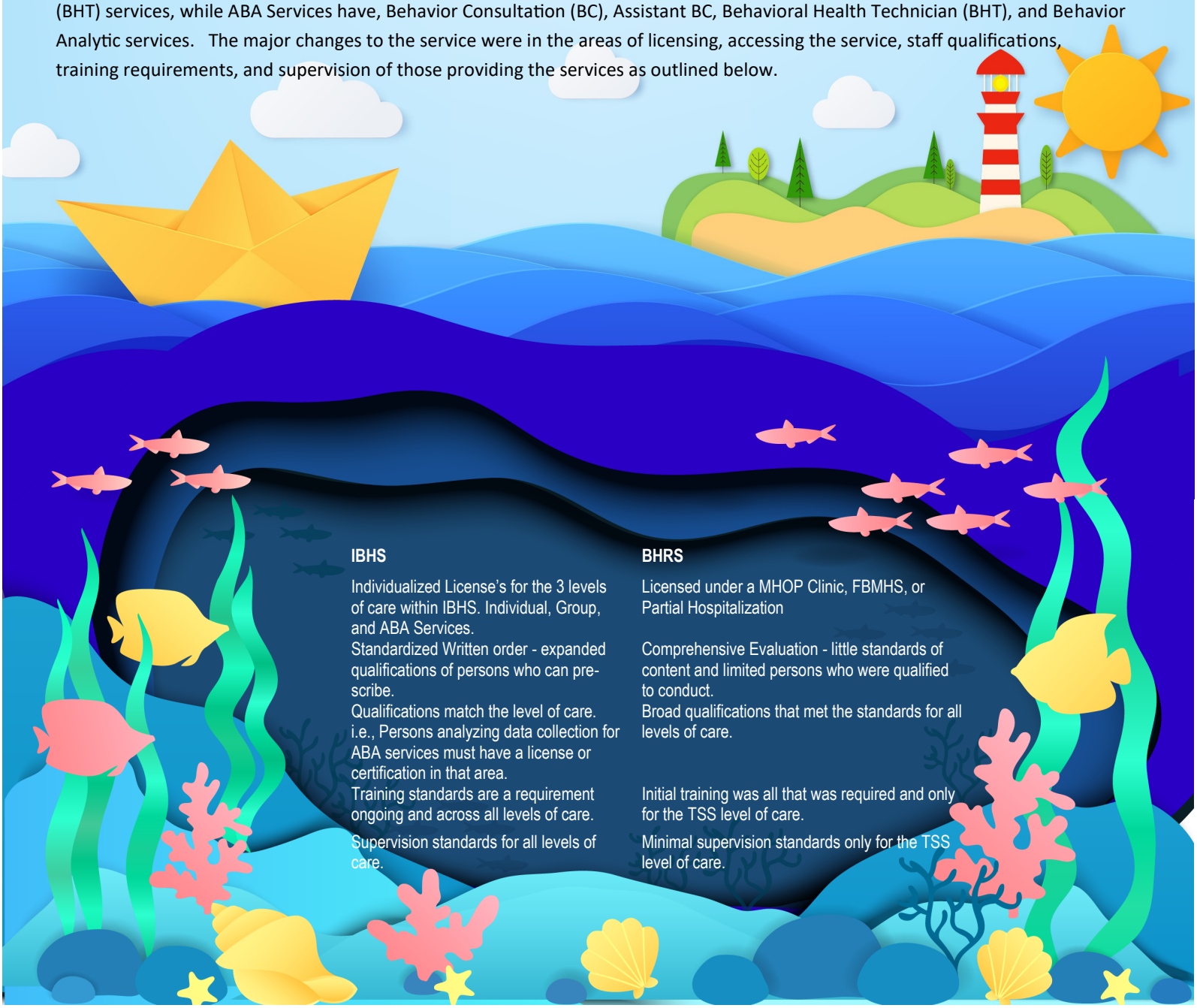
THE APA WILL CONTINUE UNTIL JUNE 30, 2021

Transition

TO INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS)

During the spring of 2016, a workgroup of stakeholders of Behavioral Health Rehabilitation Services (BHRS) was formed with the purpose of revamping and revising the current service to better meet the needs of individuals and families who utilized it. After almost 3 years of work, the new Intensive Behavioral Health Services (IBHS) regulations were published on October 19, 2019. The next 12 months were spent getting providers and BHMCO's ready for the transition. A state-wide workgroup of Primary Contractors and BHMCO's met frequently to fine-tune billing codes, service definitions, medical necessity criteria, licensing, and multiple clarifications that were necessary in order for the service to be in place by the regulation date of January 17, 2021.

Now IBHS has three separate categories of care that each carries their own set of standards and licensing regulations. They are: Individual Services, Group Services, and Applied Behavior Analysis (ABA) Services. Each category has its own levels of care (LOC) within. For example, Individual Services have Behavior Consultation (BC), Mobile Therapy (MT), and Behavioral Health Technician (BHT) services, while ABA Services have, Behavior Consultation (BC), Assistant BC, Behavioral Health Technician (BHT), and Behavior Analytic services. The major changes to the service were in the areas of licensing, accessing the service, staff qualifications, training requirements, and supervision of those providing the services as outlined below.



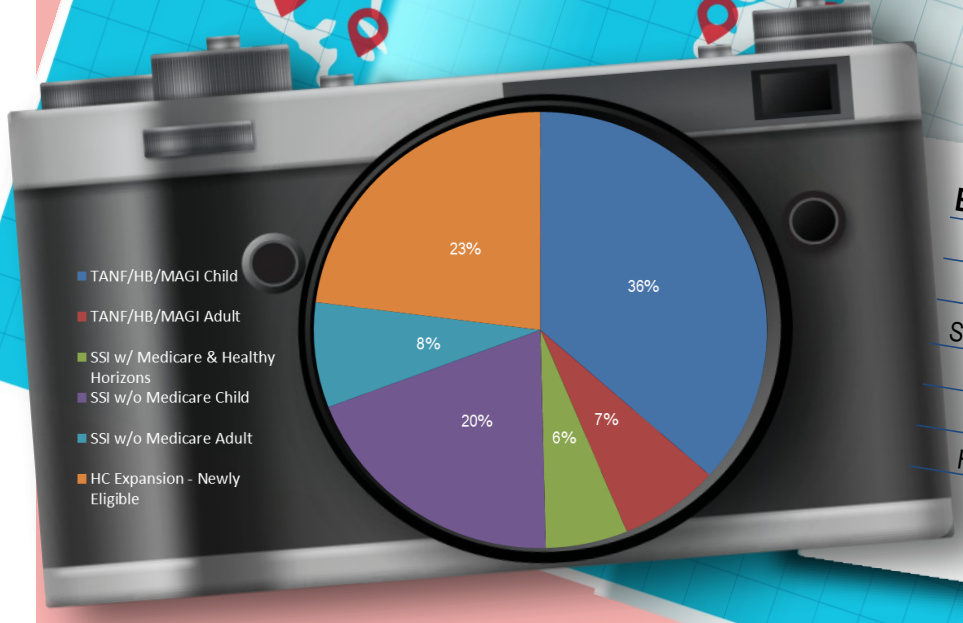
IBHS	BHRS
Individualized License's for the 3 levels of care within IBHS. Individual, Group, and ABA Services.	Licensed under a MHOP Clinic, FBMHS, or Partial Hospitalization
Standardized Written order - expanded qualifications of persons who can prescribe.	Comprehensive Evaluation - little standards of content and limited persons who were qualified to conduct.
Qualifications match the level of care. i.e., Persons analyzing data collection for ABA services must have a license or certification in that area.	Broad qualifications that met the standards for all levels of care.
Training standards are a requirement ongoing and across all levels of care.	Initial training was all that was required and only for the TSS level of care.
Supervision standards for all levels of care.	Minimal supervision standards only for the TSS level of care.

Financials

Total Gross Capitation	$61,237,185.55
Assessment/Tax	-$12,654,406.74
Net Capitation	$48,582,778.81
Claims Expense	$40,570,765.04
PerformCare Administration	$4,299,575.93
TMCA Administration	$1,758,446.13
Net Expenses	$46,628,787.10
Retained Revenue	$1,953,991.71

INTERNATIONAL PASSPORT

Checking Account	$5,356,883.65
Risk & Contingency Account	$7,568,240.36
Community Reinvestment Fund	$1,677,339.60
TOTAL CASH	**$14,602,463.61**



Breakdown by Category of Aid

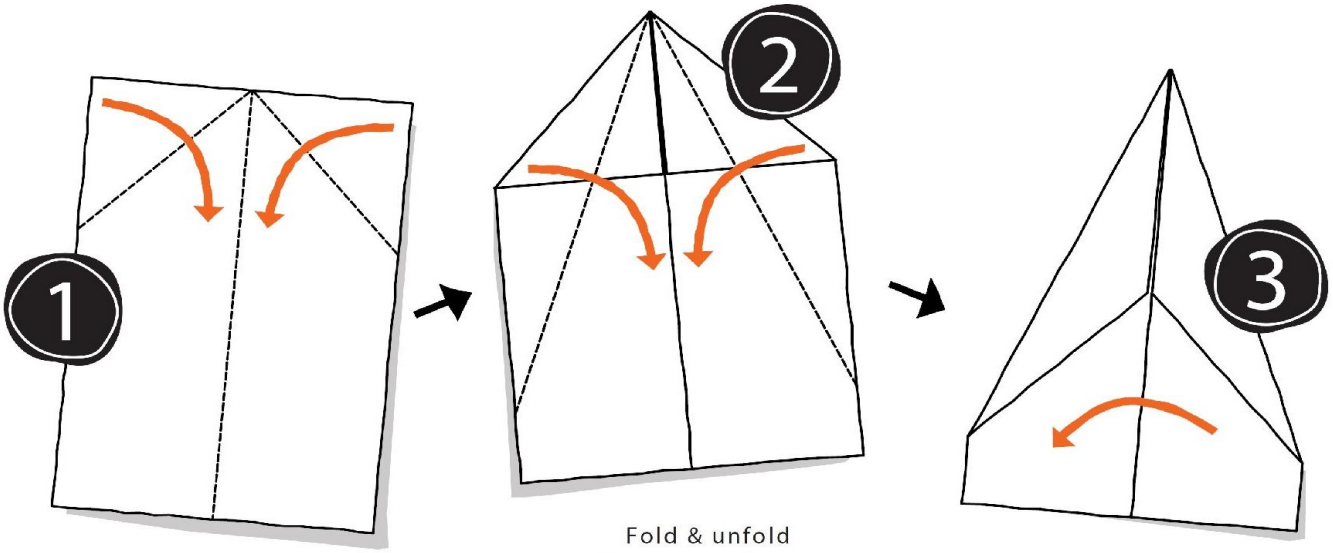
	Members	Consumers
TANF/HB/MAGI Child	19566	3353
TANF/HB/MAGI Adult	5878	1350
SSI w/ Medicare & Healthy Horizons	4362	1094
SSI w/o Medicare Child	2054	1089
SSI w/o Medicare Adult	2372	909
HC Expansion - Newly Eligible	13805	3244
Grand Total	**42957**	**9860**

PAPER PLANES

THE CLASSIC DART

LEVEL: ROOKIE ★☆☆

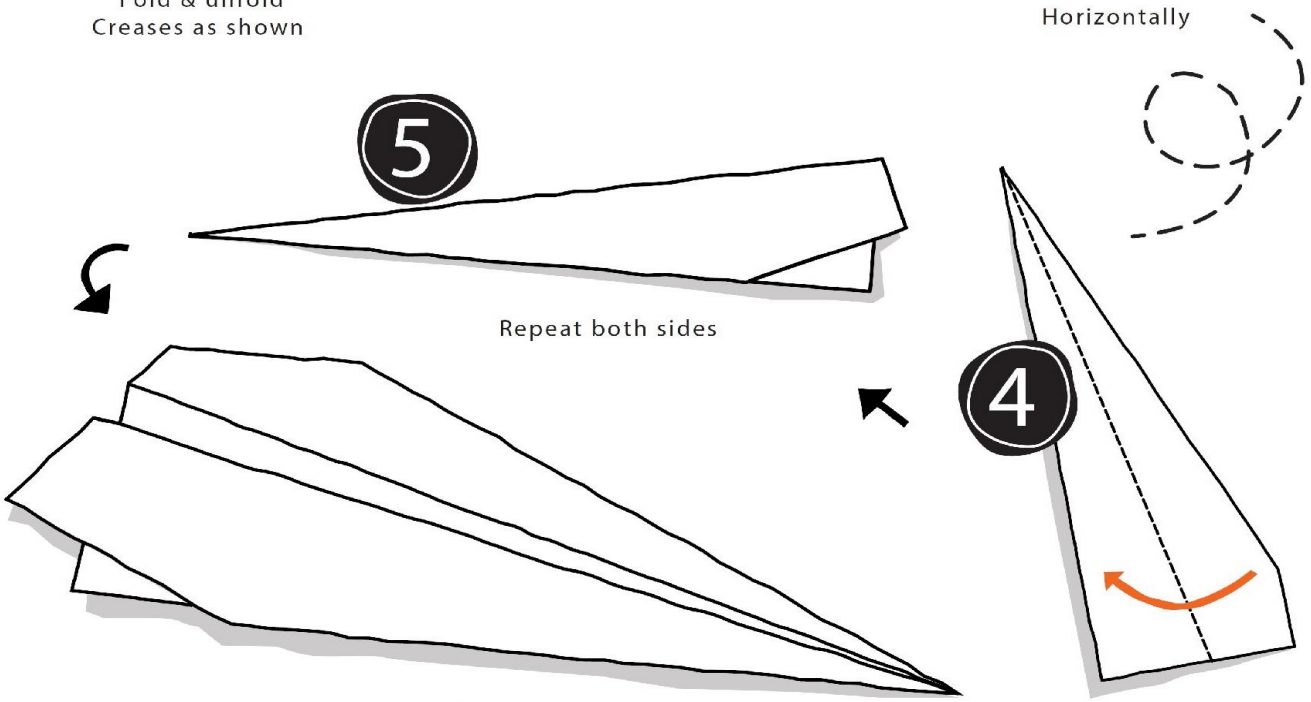
INSPIRED BY THE TRADITIONAL PLANE



Fold & unfold
Creases as shown

Fold & unfold
Creases as shown

Fold in half
Horizontally



Repeat both sides

Fold down to
form wing

FINITO!

Could not be more simple. Throw by holding the base and letting fly from fingers.