



November 8, 2012

The Honorable Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Suite 500
Baltimore, MD 21201-2301

Dear Secretary Sharfstein:

Thank you for the opportunity to provide comment on the most recent draft proposal for the delivery of specialty mental health and substance abuse services.

Attached is a copy of the proposal in which we have added our detailed and specific comments on the proposed carve out model. In these comments we address our clinical, quality, operational, and fiscal concerns about the model.

As we have made clear over the course of the past year, we strongly believe that the best path toward the triple aims (improvements in cost, quality and patient experience) is via a truly integrated benefit that is supported by detailed and specific contractual requirements that address behavioral and somatic integration.

While the details found in the attached are critically important, let me briefly highlight some of the major concerns about the proposed model:

- Care coordination and case management will be adversely impacted for patients with chronic somatic health care conditions, many of whom are also struggling with substance abuse and mental health issues
- Operational complexity and cost will be increased as two systems interface with consumers
- The care experience will be increasingly fragmented as consumers will have, for example, a case manager for somatic care and potentially another case manager for substance abuse care
- Maryland, currently a leader in the evolution of health care delivery and payment systems, will take a large step backwards

In addition, the proposed carve out does not create any savings for the State and in fact creates additional administrative costs that in many instances duplicate existing program costs.

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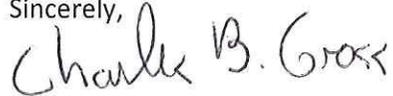
The Honorable Joshua M. Sharfstein, M.D.

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Again, thank you for the opportunity to provide further comment. If you have any questions or concerns, please do not hesitate to contact me or Kathleen Loughran at (410) 981-4009.

Sincerely,

A handwritten signature in black ink that reads "Charles B. Gross". The signature is written in a cursive style with a large initial "C".

Charles B. Gross, Ph.D.

Vice President, Health Care Management Services

cc: Charles J. Milligan, Jr., Deputy Secretary for Health Care Financing, DHMH
Vincent M. Ancona, President & CEO, Amerigroup Maryland, Inc.
Kathleen Loughran, Vice President, Government Relations, Amerigroup Maryland, Inc.

(see notes throughout document for discussion)
(note this report differs significantly from the report released and discussed on 9.13.2012- the main difference being they have shifted from risk MBHO Model 2 recommendation to ASO MBHO Model 2)

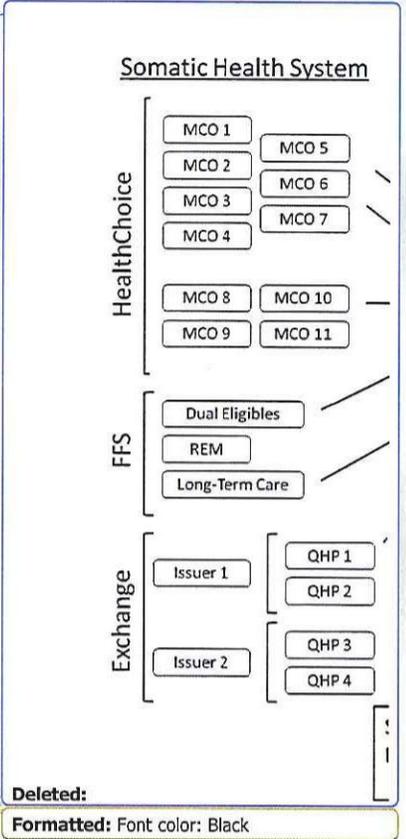
An Integration Model for Medicaid-Financed Behavioral Health Services

Recommendation delivered to Secretary Sharfstein
October 1, 2012

Introduction

This report reflects significant input from hundreds of Maryland stakeholders, and the committed efforts of many individuals across the Department of Health and Mental Hygiene (Department). It builds upon work conducted by the Department in 2011 that culminated in a consultant report. The 2011 Consultant Report recommended that Maryland should better align and integrate behavioral health services.

Comment [c1]: The consultant clearly recommended Model 1- a fully integrated benefit. While this is mentioned in body of this report, it should be mentioned here and in executive summary.



The recommendation of a model that improves the integration of Medicaid-financed behavioral health services, presented in this report, represents a major milestone. Significant work still lies ahead. The Department greatly appreciates the contributions of everyone who has participated thus far and we look forward to continuing to work with stakeholders in the coming months to improve health care in Maryland.

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Executive Summary

The process of selecting an integration model for Medicaid-financed behavioral health services is comprised of three phases. The first phase began in 2011 and involved collaborative work between the Department, a consultant, and stakeholders in order to assess the strengths and weaknesses in Maryland’s current system. While noting the strengths in the current system, including generally good access in each service domain (mental health, substance use treatment, and somatic care), the resulting report reached five conclusions: (1) benefit design and management across the domains are poorly aligned; (2) purchasing and financing are fragmented; (3) care management is not coordinated; (4) performance and risk are lacking; and, (5) care integration needs improvement.

Phase 2 of the process began in early 2012 as the Department and stakeholders set out to

Comment [c2]: The consultant report clearly recommended Model 1- full integration. While this report mentions this in body, it should be mentioned in Executive Summary, since the DHMH has chosen to ignore it’s own consultants recommendation.

develop a broad financing model to better integrate care across the service domains. After review of the various options, a cross-disciplinary leadership steering committee within the Department (Steering Committee) now offers its recommendation to Secretary Sharfstein that Maryland pursue a transformative behavioral health carve-out that combines treatment for specialty mental illness and substance use disorders under the management of a single administrative services organization (ASO).

Comment [c3]: What was vote? Unanimous? Split? Were written records kept? Those should be incorporated into report

Comment [c4]: This recommendation is not transformative, unless one considers a regression to an outdated version of managed care transformative.

To be transformative, an ASO model that includes treatment for mental illness and substance use disorders must reward outcomes and performance, and not volume. Similarly, the managed care organizations (MCOs) that deliver somatic care to the majority of Medicaid beneficiaries through the HealthChoice program also must operate within a system that rewards positive behavioral health outcomes for individuals served in both the MCOs and the specialty behavioral health carve-out.

A performance-based ASO could offer many of the advantages of a capitated carve-out model utilizing a managed behavioral health organization (MBHO). Yet, this only is true if the ASO and behavioral health providers embrace a new type of ASO model that drives value and outcomes in ways that the current ASO model for specialty mental health services does not. Hallmarks of a transformative ASO model could include:

- ☑ Financial performance risk (likely including shared savings) at the ASO level;
- ☑ Financial performance risk (which could include shared savings) at the behavioral health provider level;
- ☑ Incorporation of behavioral health financial incentives at the primary care and MCO level;
- ☑ Incorporation of non-financial tools that distinguish providers who achieve positive outcomes from providers who achieve average or poor outcomes, including tools such as differential rules for prior authorization, utilization review, and consumer self-referral.

Comment [c5]: What are the thoughts of the steering committee on what these will be? The issue of determining accountability and ownership for changes that occur within the MCO sphere is very challenging and not without controversy. Will the steering committee also incorporate shared risk in instances where a patient's behavioral health disorder(s) lead to poor medical outcomes?

In order for a behavioral health carve-out to succeed, the Department also needs to improve the existing relationship between primary care and specialty behavioral health, and between the MCOs and the ASO. Specific changes could include:

- ☑ Requiring an MCO to assign a care coordinator when one of its members receives services in the specialty behavioral health system;
- ☑ Developing policies and approaches to coordinate (or integrate) primary care with the specialty behavioral health services provided through the new behavioral Health Home;

Comment [c6]: The cost of these services will be duplicative, and add to the overall admin costs, in a way that fully integrated benefit does not.

- ☑ Increasing bi-directional data sharing between the MCOs and the ASO to improve beneficiary care, which could include an approach that aligns electronic health records; and
- ☑ Shared savings models across somatic and behavioral health.

Many of the underlying details will be resolved in Phase 3 of this project: developing the specific operating rules, contract provisions, and financial incentives in both the carve-out and in HealthChoice.

Comment [c7]: The details of these models are challenging at best- and will lead to duplication of admin structures on both sides to track, and also are an unnecessary component that accompanies Model 2- if one attempts to also move from volume to performance based payment.

The Steering Committee’s recommendation reflects its determination that Maryland’s behavioral health delivery system is ready to embrace a model premised on pay-for-performance, outcomes, and value-based purchasing. If the Steering Committee’s determination is misplaced, and if the behavioral health system instead seeks to protect a more traditional fee-for-service system that rewards volume over value, then Maryland’s willingness to consider a performance-based ASO might need to be abandoned even before it begins. Absent a broad stakeholder willingness to embrace change that improves integration and outcomes within an ASO model, Maryland might need to immediately move toward an insurance-based MBHO model.

Comment [c8]: This is a dramatic shift from the model presented and responded to on 9.13.2012. By moving to ASO versus risk, while at the same time trying to transform the system from volume based payment model to performance based payment model, the Department is adding a level of complexity that is frankly unnecessary. A better way to transform the system from volume to performance is Model 1- with a detailed and specific contract with the MCO’s that mandates pay for performance, shared savings across somatic and behavioral, separate MLR for behavioral, and- if deemed necessary, perhaps a developmental timeline over which the Department would lead the system from current carve out to: first, an integrated ASO BH benefit with performance targets for the MCO’s (perhaps adding BH specific VBP measures) , contractually protected MLR based on prior State experience with mental health costs and shared savings model, and then over time to a full risk integrated BH somatic model.

What follows is a synthesis of the reasoning behind the carve-out recommendation.

Strengths

A carve-out administered by an ASO would cover all Medicaid eligibles, as opposed to just Medicaid beneficiaries who receive their care from MCOs. A carve-out would spare behavioral health providers from having to navigate different provider credentialing, prior authorization, utilization reviews, payment rates, and contracting practices of multiple MCOs. Also, a single statewide carve-out would be more adaptable to program changes on the somatic side if, for example, MCOs change service areas or withdraw, or if the Department develops new models to serve Medicaid-Medicare dual eligibles. This model provides one point of contact for all behavioral health services, simplifying linkages to and coordination with non-medical systems. Lastly, an ASO would create a single point of contact as individuals move between Medicaid and the Maryland Health Benefit Exchange.

Comment [c9]: The repeated emphasis on one point of contact and making this easier for behavioral health providers may have some merit. However, I think this point can be addressed in either Model 1 or 2. For example, the Department could create a DHMH BH integration Council and require the MCO’s to participate, mandate the nature and intensity of their participation, mandate the nature of the data to be reported and form of the data to be reported, set the meeting schedules, mandate who else must participate in this Council (i.e. everybody on either side of the illustration for Model 1— MCO’s, QHP’s, Criminal Justice System, Housing, Dept of Aging, Public Health, Dept Transportation, etc). My point is that the Department could take Illustration 1, and replace Model 2 Entity in the middle with the BH Coordinating Council, and have the same level of coordination and stream lining that they currently site as one of the main reasons for recommending Model 2.

Challenges

A carve-out is not without its challenges. Foremost among them is the fact that this model does not reflect true integration across all three systems: mental health, substance use treatment, and somatic care. A carve-out will require significant care coordination tools as individuals will be treated in two systems: one for their somatic care (including primary care) and another for their specialty behavioral health care. An additional challenge is resolving payment disputes that arise when both the MCOs and the ASO refuse to authorize payment to a provider (usually a hospital), asserting the other system should pay.

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Certainly, there is no magic bullet here. Any model would face its challenges. The Steering Committee offers the recommendation in the following pages because of its judgment that this model is best for Maryland, and for the Medicaid beneficiaries we serve.

Comment [c10]: The entire movement at the Federal and State level is toward fully integrated care. One might argue that the State is doing worse than standing still, it is going backwards. Then, in an attempt to ‘transform’ the system, the Department is considering layering on a pay for performance infrastructure- with the direct threat that if providers do not go along, they will be punished by being placed in an at-risk carve out.

Background

The Need for Integration in Maryland

There is significant overlap between individuals with mental illness and those suffering from addiction. While many people suffer from one condition but not both, experts advise “[d]ual diagnosis is an expectation, not an exception.”¹ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that only 7.4 percent of individuals in the United States with co-occurring disorders are treated for both conditions and more than half do not receive treatment for either. In addition, many with mental illness, addiction, or dual diagnoses have significant chronic, somatic health conditions such as diabetes or heart disease. These conditions are largely responsible for the significant gap in life expectancy between those with serious behavioral health disorders and those without.

¹ Minkoff, K., and C. Cline. (2004). Changing the World: Integrated Systems of Care for Individuals with Co-Occurring Disorders. *Psychiatric Clinics of America*, 27(4).

Maryland’s current financing and delivery system has many commendable attributes, including greatly improved access to care in recent years in each separate domain (mental health, substance use, and somatic services). However, care across these domains often is fragmented, which poses unique difficulties for consumers with complex health conditions seeking treatment in two or more health systems:

- ☑ Medicaid pays for specialty mental health through a carve-out ASO arrangement administered by the Mental Hygiene Administration;
- ☑ Medicaid pays for somatic treatment and some behavioral health services in primary care settings;
- ☑ Medicaid pays for substance use disorders in the HealthChoice and Primary Adult Care (PAC) programs, which are capitated and administered by MCOs; and
- ☑ Local jurisdictional grants provide access to addiction services.

These disparate paths too often fail to connect to provide coordinated care for consumers. The combined cost of medical care, substance abuse treatment, and mental health care for high-cost, high-need individuals can reach hundreds of thousands of dollars per person per year, and many co-morbid conditions are left untreated. Moreover, providers in one system often are unaware of services in other systems. An incentive to deliver preventive care in one system might not be strong enough if the resulting savings benefit another system. For all these reasons, and more, Maryland must improve the efficiency and efficacy of our care systems, not only for consumers with serious behavioral health needs, but also for individuals with more routine health care needs.

Overview of the Current System

Maryland is not unique in the fragmentation of its publically supported behavioral health care system. Though all three contracting and oversight entities (Medicaid, Alcohol and Drug Abuse Administration, and Mental Hygiene Administration) are located within the Department of Health and Mental Hygiene, each has independent funding streams, management structures, and payment arrangements. As a result, consumers currently navigate multiple systems in order to receive somatic and behavioral health care.

Comment [c11]: The report needs to emphasize the significant overlap between members with SA/ MH and somatic care. As has repeatedly been demonstrated at the Maryland State level as well as at the national level, Medicaid consumers with complex medical needs also carry a significant disease burden from the mental health and substance abuse perspective(s).

Comment [k12]: Medicaid pays for somatic treatment and some behavioral health services in primary care settings in the HealthChoice program. HealthChoice pays for pharmacy benefit for substance abuse and some mental health care.

Comment [c13]: Many/most of the new models of care for Medicaid are moving away from fragmentation and toward a truly integrated benefit (see TN, KS, KY, TX)

Somatic Care

Approximately 80 percent of all Maryland Medicaid beneficiaries receive somatic health services through a managed care organization (MCO), and this number will increase in January 2014 after the Medicaid expansion under the Affordable Care Act occurs. In fact, participation in managed care is mandatory for most Medicaid beneficiaries in Maryland. Maryland's HealthChoice (full benefit) and PAC (partial benefit) programs, authorized by Medicaid's 1115 waiver, are responsible for providing somatic care to all enrollees through a risk-based, capitated payment system. As of August 2012, seven MCOs were participating in the HealthChoice program, with five of those seven participating in the PAC program. Providing managed care in Maryland requires ensuring access to services, meeting certain quality measures, collecting and analyzing encounter data, and participating in performance improvement projects as defined by the Department. Any MCO that meets the standards set by the Department can participate in HealthChoice; any HealthChoice MCO can participate in PAC.

The remaining 20 percent of beneficiaries receive their somatic care through a fee-for-service (FFS) system. Populations whose services are paid FFS include individuals over the age of 65, dually eligible for Medicare and Medicaid, living in institutional health care facilities, in the Rare and Expensive Case Management (REM) program, or on certain Medicaid waivers.

Mental Health Care

All Medicaid beneficiaries may receive primary mental health services from their primary care provider. These include a clinical evaluation and assessment of services needed, as well as the provision of services and referral for additional services. Specialty mental health care is carved-out into a managed FFS program, which has been provided by an administrative services organization (ASO) under contract to the Mental Hygiene Administration (MHA) since 1997. MHA is responsible for providing all medically necessary specialty mental health services. (MCOs are only responsible for providing mental health services that can be provided by primary care providers.) All Medicaid beneficiaries, both those in managed care and in FFS, can receive services through the specialty mental health system. Limited mental health services for the uninsured are paid with state funds through the ASO. The ASO's responsibilities include operating a utilization management system, paying claims, providing data collection and management information services, offering public information, consultation, training, and evaluation services, and managing special projects.

MHA is responsible for planning, managing, and monitoring the Public Mental Health System in Maryland. MHA assigns to core service agencies (CSAs) the responsibility to provide information and referrals to individuals and families, handle complaints, and monitor contracts. The CSAs work in collaboration with other systems, develop innovative services, and monitor providers for compliance and quality.

Substance Use Disorder Treatment

The Alcohol and Drug Abuse Administration (ADAA) is responsible for the planning, coordination, and regulation of the statewide network of substance use disorder prevention, treatment, and recovery services. ADAA provides state-funded grants to the 24 local jurisdictions and Baltimore City, largely through the Local Health Departments (LHD). ADAA grant dollars cover services for the non-Medicaid eligible population as well as non-reimbursable services for the full Medicaid and PAC populations.

Comment [k14]: If Option 2, is selected, should also carve out primary mental health services and all pharmacy benefits for substance abuse and mental health including buprenorphine. Currently, certain mental health drugs are carved out.

LHDs provide a wide array of substance use disorder services, which are funded through a combination of State (ADAA and other agency), local and Federal grant dollars, and client fees. LHD Jurisdictional Coordinators plan a continuum of services specific to the assessed needs of their jurisdiction. They can provide services directly, contract with community-based private and non-profit providers, or combine direct and procured services for both Medicaid and non-Medicaid reimbursable services. All contracted providers assess a fee for service based on the client's ability to pay, and determine if a client has PAC or MA prior to billing the jurisdiction or using ADAA grant dollars.

Medicaid reimburses substance use disorder services through its managed care delivery system. Beneficiaries enrolled in the PAC program are covered for a comprehensive assessment, outpatient individual and group counseling, intensive outpatient services, and opioid maintenance treatment. The HealthChoice program covers these services, as well as partial hospitalization, youth residential and inpatient treatment, and medically managed inpatient detoxification. Those in a Medicaid managed care program self-refer to substance use services. Services not covered by full Medicaid or PAC are covered by the funding sources described above. Some examples of non-Medicaid reimbursable services include: information and referral, prevention, residential treatment for adults, and recovery support services, as well as coordination of care between other service systems and system management.

Health Care Reform and Behavioral Health

Individuals with behavioral health needs often face barriers accessing care in both the private and publically-funded insurance systems. Many private insurers do not cover or limit the use of behavioral health services, while publically funded services remain fragmented and difficult to navigate. Additionally, many low-income individuals without children or above Medicaid's income threshold are ineligible for services despite an apparent need. The implementation of health care reform under the Affordable Care Act (ACA) provides an opportunity to address these issues and significantly improve access to quality care for those with behavioral health care needs.

Beginning in 2014, provisions in the ACA will allow Maryland to expand Medicaid eligibility to most individuals under 138% of the federal poverty level (FPL), and these individuals will qualify for Medicaid's behavioral health benefits. In addition, Maryland's state-operated health benefit exchange will require all participating health plans to cover the ACA's "essential health benefits", including behavioral health services. The need for grant-funded services is expected to decrease as private and public insurance coverage extend to many of those individuals who now lack health insurance; indeed, Medicaid is the dominant payer of health services for low-income individuals, and will become even more dominant in 2014. Grant-funded services will likely still be necessary for residential, educational, employment, and other services.

The Integration Process

As part of the State FY 2012 budget (for the fiscal year July 1, 2011 – June 30, 2012), the Maryland General Assembly asked the Department of Health and Mental Hygiene to convene a workgroup and provide recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues." In making this request, the General Assembly recognized the current need for improved coordination in Maryland's approach to individuals with behavioral health conditions.

Consultant Work in 2011

In 2011, the Department engaged an experienced consultant to examine the current system, consider integration options, and provide recommendations regarding financing structures to best support integrated care. The consultant conducted five structured interviews with mental health and addictions treatment providers, consumers, families, advocates, CSAs, and state officials. These interviews focused on two key questions:

- What would an integrated system in Maryland look like in terms of practice, delivery platform, benefits management, and financing?
- How could Maryland move to an integrated system?

The consultant reviewed other states' experiences and identified innovative approaches that would achieve the three goals of effective health care delivery: a better consumer experience, lower costs, and improved outcomes.

One hundred and twenty eight stakeholders attended three listening sessions held in early September 2011. Participants' shared their insights on how Maryland can capitalize on health reform to create a better-integrated system of care. These listening sessions focused on four questions:

- What would an integrated system in Maryland look like in terms of practice, delivery platform, benefits management, and financing?
- How could Maryland move to an integrated system?
- What are the features of the current system that support integration?
- What are the opportunities for improvement in the current system in terms of integration, patient-centered care, and health and wellness?

The consultant held two additional stakeholder meetings in mid-November in Annapolis and Frederick, at the request of stakeholders, to give input on the options being considered by the consultants. Approximately 80 stakeholders attended these two meetings.

The Consultant Report provides an assessment of Maryland's behavioral health care system, confirming that the State invests considerable resources in behavioral health care, with thousands of citizens benefitting from high quality, compassionate, and evidence-based care each year. However, the report also noted that our current system largely pays on the basis of the volume of services rather than measurable health outcomes such as recovery and reductions in avoidable hospitalizations, other outcomes such as employment and reductions in homelessness, cost-effectiveness, or overall value. The report made the following observations about Maryland's current system:

- Benefit design and management are poorly aligned;
- Purchasing and financing are fragmented;
- Care management is not coordinated;
- Performance standards and risk are lacking; and,
- Integrated care needs improvement.

The report details a number of innovative integration efforts underway nationwide that could be replicated in Maryland. Looking to 2014, when the full implementation of health reform will precipitate a range of changes in state health care (including the transition of the Primary Adult Care program into a full-benefit Medicaid program), the report proposes two alternative models for moving forward:

- Option 1 is described as a "protected carve-in." Under this model, Maryland would bundle funding for medical care, mental health and substance abuse in the HealthChoice program. The carve-in of behavioral health services would be "protected" because the model would ensure adequate and identifiable funding for behavioral health services. The Consultant favored this approach on the grounds that the establishment of a responsible organization for each individual would provide a powerful incentive for integrated care and prevention. There remain, however, important questions about the readiness of managed care entities to truly integrate care and incentives. Often, a traditional managed care entity simply subcontracts the provision

Comment [c15]: This needs to be highlighted in executive summary

of behavioral health services to another entity, creating siloed systems not unlike Maryland's currently fragmented system.

- Option 2 is described as a "risk-bearing carve out." Under this model, Maryland would hire an organization to manage behavioral health benefits (both substance abuse and mental health) under some form of performance and/or financial risk model, and this entity would coordinate the services for which it has responsibility with the physical health benefits now managed by the MCOs in the HealthChoice program. The consultant disfavored this approach on the grounds that, while it would improve the coordination between mental health services and substance abuse services, and while it would create a model focused on outcomes and value, it nevertheless would fail to integrate behavioral health and medical care, and it would fail to align incentives for better outcomes across both behavioral health and medical care.

Comment [c16]: This issue can be addressed by the Department via a contract with MCO that specifies what BH services and staff they are required to have as part of their integrated MCO product- i.e. some back room ops might be subcontracted but case management, care coordination, quality etc have to be provided within the MCO

Comment [c17]: Exactly the challenge of Model 2 exists in the proposed ASO model. In fact, an ASO arrangement further insulates the vendor from responsibility for cost and quality outcomes.

Principles for Integration

Following the publication of the Consultant Report, seven principles were developed by Secretary Sharfstein and the Department to guide the next steps forward choosing a specific integration strategy:

1. A new system should provide the greatest value to Maryland consumers. Individuals and families should be able to access the right services at the right time to remain as healthy and productive as possible.
2. A new system should support effective models of integrated care. These models include health homes, where medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan for the whole person.
3. A new system should prioritize the needs of the seriously ill. Special attention must be paid to assure coordinated care for especially vulnerable Marylanders who experience severe mental illness or substance abuse disorders.
4. A new system should integrate financing for substance abuse and mental health treatment services. Given the high degree of comorbidity, our financing system should not fracture along the lines of diagnoses within behavioral health.
5. A new system should provide payment on the basis of performance, value and outcome, and not just volume. Such payment reform transformations are occurring throughout the health care financing and delivery systems for all payers and services, and the behavioral health system must join this movement to align incentives with prevention and health for Marylanders.
6. A new system should include a strong role for local oversight and engagement. The financing system should provide comprehensive service and outcome data to localities. Currently, localities receive only a fraction of important data about the care of their residents. More full information will allow for the identification of unmet needs and the design of programs to address them.
7. A new system should be able to coordinate well with other systems, including the criminal justice, education, and child welfare systems, to promote social outcomes such as successful community reintegration, adoptions and permanent placements, school achievement, and others.

Recommending a Model

In early 2012, the Department established a Steering Committee led by the Deputy Secretary for Health Care Financing to review the financing and integration options. Membership included representatives from all key programmatic units at the Department (see Appendix III for complete Steering Committee membership).

Between March and September 2012, the Department held a series of large public stakeholder meetings to inform the selection of a financing model. The Steering Committee developed three documents, which were circulated for public comment and finalized as the first charge of this stakeholder process. The Department used these documents to guide the rest of the process. Building on work done to date, the first document described three proposed finance and integration models (two of which were outlined in the Consultant Report, and a third added by the Steering Committee) (see Appendix VI). The second document presented eleven criteria for stakeholders and the Steering Committee to use when evaluating the three models, such as ensuring delivery of the right service, in the right place, at the right time, by the right

practitioner (see Appendix VII). The third document charged four workgroups with the task of addressing specific issues related to the selection of a financing model, augmenting the large public stakeholder meetings (see Appendix IX).

The Department developed an email list that ultimately included 831 individuals, and distributed all materials, meeting announcements, and resources through this list. The Department accepted comments, both in writing and in twenty-four public meetings from May through September 2012, and the Department used a webinar approach for all these meetings to allow individuals to participate across the State without needing to attend in-person. Issues and discussions that arose in each workgroup informed the large public stakeholder meetings, and the Steering Committee compiled reports from each workgroup to inform the Committee's final decision regarding model selection. These workgroup reports are available as Appendices XI-XIV.

This report and the final recommendation are the culmination of all behavioral health integration efforts since 2011. The Steering Committee would like to thank its members, the Consultant, stakeholders, and all other contributors for their invaluable input to this process.

Model 1: Protected Carve-In (Recommended in Consultant Report)

Medicaid-financed behavioral health benefits would be managed by Medicaid managed care organizations (MCOs) through a "protected carve-in". The MCOs would be responsible for managing a comprehensive benefit package of general medical and behavioral services. MCOs would receive a separate, dedicated behavioral health capitation payment that only could be spent on behavioral health treatment and recovery supports. Any savings related to behavioral health services would be re-directed to additional, innovative behavioral health benefits. Contractual conditions would require the MCOs to employ specific behavioral health practitioners in clinical leadership positions, would specify the credentials of staff who performed behavioral health utilization management, and would put the MCOs at risk for demonstrating that they were assuring access to the behavioral health benefit. This model would protect funds spent on behavioral health treatment but would allow the MCOs to have flexibility in how they structured care coordination, utilization management, etc. Contractual conditions would require uniform processes for providers (e.g. claims payment, credentialing) and streamlined administrative systems. Specific behavioral health performance standards would allow the State to evaluate access, adequacy of the provider network, treatment quality, and outcomes for cohorts of enrollees, e.g. adults with serious mental illness, youth with complex needs, etc.

Under Model 1, an MCO could manage behavioral health care in one of three possible ways. The first would be to fully integrate behavioral health into its current structure without subcontracting to a behavioral health organization (BHO). The second option would allow MCOs to subcontract with a BHO of their choice. The third would select a statewide BHO with whom all MCOs must subcontract for behavioral health services.

One of the advantages of integration in Model 1 is that health care overall should improve as consumers receive the whole body care they need. As a result, the health care system should see cost savings on the somatic side as a result of improved behavioral health treatment, and vice versa. A strong advantage of Model 1 is that having one entity responsible for both somatic and behavioral health care ensures savings are retained and able to be reinvested in the right system. In other words, an MCO might have an incentive to invest in preventive behavioral health services because these costs might reduce the MCO's costs related to emergency room visits and hospital admissions. Thus, Model 1 would avoid a potentially complex cost allocation methodology would not be necessary to distribute savings to the appropriate entity.

Another advantage to this model would be continuity for consumers. As individuals' health care needs or the needs of their family members change, under another model they could be forced to switch entities, such as from MCOs to a managed behavioral health organization under Model 2. Further, the definitions of "behavioral health need" and "severe behavioral health need" will continue to change over time. This could affect the criteria to be eligible for a specialized entity under Models 2 or 3, such that individuals become ineligible to have their care managed by the specialized entity simply due to a change in definitions. A reality of any model other than a fully integrated model is ongoing administrative activity around these changes. Under Model 1, as health care needs and definitions change, individuals will always have their care managed by the same entity.

Under a fully integrated model, there is no potential for adverse selection between entities. No matter a person's health status, the same entity is responsible for his/her care. This could have many benefits, including: (1) keeping costs down by preventing adverse selection among entities; (2) maintaining

Comment [c18]: While this is one version of integrated care (mental health, substance abuse, somatic care) there are over versions of integrated care that the DHMH needs to consider. For example, a Model 1 can be developed that addresses all of the concerns cited in this report, while also at the same time reflecting true integration. To give a brief sense of what this might look like- here is very schematic outline for the form this Model 1A might take- DHMH, stakeholders and MCO's would develop:

1. ASO for the initial period (to be determined via stakeholder input) with a variety of specific value based behavioral health specific performance metrics
2. Standardized auth rules by LOC
3. Standardized fee schedules
4. Standardized credentialing process and standards
5. Standardized PQIP (performance quality improvement program)
6. Shift to at risk basis with protected MLR for behavioral health after initial ASO (year 3 of program?)
7. Development of behavioral health home standards, criteria, RFP process with MCO's and DHMH input- this would allow development of health homes by assuring patient volume sufficient to fund health home infrastructure and additional services

Comment [c19]: One would also expect quality and health care outcomes improvements to grow from model 1. These expectations could be built into the contract with the MCOs and be tied to performance rewards and penalties.

accuracy in data (as providers are concerned with different diagnoses being reimbursed differently); and (3) better whole body care across the lifespan.

Most of the disadvantages of Model 1 are linked to one of the three potential ways an MCO could manage behavioral health care. There is a significant amount of fear among many stakeholders in the behavioral health system (providers and consumer advocates) that MCOs will deny care in order to improve their financial margins – a view rejected by the MCOs, but stakeholder concerns remain.

Data collection presents another concern relating to MCOs' current operations. At present, some feel that collecting data from MCOs is neither timely nor transparent due to the diverse systems and regulations of the multiple MCOs.

Many stakeholders were also apprehensive about this option because Maryland Medicaid MCOs generally lack experience providing specialty mental health services to people with serious and persistent behavioral health needs, such as providing psychiatric rehabilitative services or mobile treatment. Some stakeholders felt this may have negative consequences for consumers. If this option is selected, the specifications outlined in Phase 3 would be particularly important to ensure the system strengthens its current weaknesses.

Allowing MCOs to subcontract with a BHO of their choice may alleviate some of the concerns associated with the current MCO system. However, behavioral health providers may be frustrated by the potential administrative and logistical challenge of working with up to seven MCOs and multiple BHOs with different claims, credentialing, and authorization systems. In addition, this could result in seven different provider networks for somatic care and multiple additional provider networks for behavioral health care, which could be very complicated for the behavioral health population. It is possible that the State could streamline these systems, and this should be considered if this option is recommended.

If the State selected a single BHO with which MCOs must contract for behavioral health services, it may alleviate many of the above concerns. However, MCOs may prefer not to be told with whom to do business, especially if the MCO has an existing corporate or other relationship with a BHO, and the BHO may not work well with each of the seven different entities.

Conceptually, stakeholders supported a fully integrated model like Model 1. Some stated that this model represented an ideal toward which Maryland should work. Realistically, however, most did not believe the current system would be capable of a successful transition to this model.

Comment [c20]: While these concerns are understandable, the Department can address these in a variety of ways. The concern about profit can be addressed contractually via a separate MLR for behavioral health. In addition, a developmental timeline, starting with an ASO arrangement would be another potential way to address these concerns. As mentioned above, these two approaches might be combined, with the Department starting with ASO arrangement for behavioral health within the MCO's and over time moving to an at risk contract with a discreet MLR for behavioral health services.

Comment [c21]: A challenge that can be met in a variety of ways. For example, the Department could mandate the nature of the provider-MCO interface. This might take the form of a common web site front door for behavioral health services via which providers would interface with all MCO's. This website would be used to enter auth requests, gather eligibility information, file claims, check on claims status- etc. While the development of this common front door platform would require a significant amount of work, it is doable.

Comment [c22]: This is not true for the largest MCO's currently operating in Maryland. The Department could develop a minimum set of standards that any MCO would have to meet re SPMI expertise.

Comment [c23]: See comment 16

Comment [c24]: Current mental health credentialing is done by who? Who sets credentialing standards? I thought mental health network is the State's and they credential. Again, the Department can set universal credentialing standards and processes if it chooses to.

Comment [c25]: Department recommendation should move in this direction by adopting a version of Model1- or creating a version of Model 1, perhaps Model 1A, that moves in this direction. Instead, the recommendation for an ASO Model 2 is regressive, transforming the current bifurcated system even further away from true integration.

Comment [c26]: See comment 16 for graduated approach to integrated care

Model 2: Risk-Based Service Carve-Out (Presented in Consultant Report)

Medicaid-financed specialty behavioral health benefits and the State/block grant-funded benefit package would be managed through a risk-based contract with one or more Behavioral Health Organizations (BHO). Using a competitive selection process, Medicaid would contract with one or more BHO(s) that would bear insurance and/or performance risk. Contractual conditions would be aligned with those of the Medicaid MCOs; performance standards would be robust; and performance risk would be shared with MCOs for continued implementation of health homes for persons with behavioral health conditions, as well as health homes for persons with chronic medical conditions and for improvement in health outcomes for persons enrolled in health homes. The services delivered through the BHO(s) would be specialty behavioral health services. MCOs would continue to provide specified behavioral health care typically associated with primary care providers.

Under this model, a specialized entity would be responsible for behavioral health benefits, separate from the entity(ies) responsible for somatic care (MCOs). There could be one or multiple specialized entities; the entity(ies) could take on either insurance risk or performance risk. In other words, there could be one or more managed behavioral health organizations (MBHOs) or one or more administrative service organizations (ASOs) managing behavioral health services for the total population.

Most stakeholders supported a single MBHO/ASO under Model 2. Contributors pointed out that having more than one MBHO/ASO could be very complicated and burdensome for providers. Like Model 1 in the case where each MCO could subcontract with the BHO of their choice, Model 2 with multiple MBHO/ASOs could mean providers having to deal with two or more entities on the behavioral health side in addition to the seven MCOs. As provider qualifications, contracting standards, covered benefits, financing structures, and others could all vary by entity, this could get complicated and administratively burdensome for providers. A single MBHO/ASO with a closed provider network may limit consumer choice of providers and, thereby, limit access. It may also lead to the MBHO/ASO having significant power that would otherwise remain checked by competition were there multiple entities. However, multiple MBHO/ASOs could also be complex for consumers who may potentially have to change MBHO/ASOs, which may mean navigating a new provider network, different covered services, etc.

An advantage to a specialized entity managing all behavioral health services for the total population (as opposed to an entity managing all services) could be that this entity has the tools, experience, and focus to best manage care for these services specifically. Unlike under Model 1, an MBHO/ASO would have experience providing specialty behavioral health services. They may also be better equipped to conduct outreach and education, provide customer service, design provider incentives, and offer services in a way that is most beneficial to the population needing specialty mental health services, compared to an entity who only has experiencing managing somatic care services.

Model 2 in particular could allow consumers to get the full array of services they need, as non-Medicaid services could be supplemented with grant-funded services (with all funds managed by the MBHO/ASO).

A single MBHO/ASO could allow for richer data and measures on a population level because the MBHO/ASO would focus solely on the behavioral health population (and would focus on the entire population who receive behavioral health services). Data may be more streamlined and timely under this model than under the other two models. Behavioral health providers may benefit from a single MBHO/ASO managing all behavioral health services as opposed to MCOs under Model 1, as a single MBHO/ASO may increase the efficiency with which providers are credentialed or form partnerships to effectively deliver the services. For instance, it may be easier to coordinate Medicaid services with grant-funded behavioral health services if the MBHO/ASO has a relationship with non-Medicaid systems. In this way, the behavioral health population may also benefit from this model. In addition, working with a single MBHO/ASO would be less administratively burdensome for providers and for the State, who would only have to modify a single contract to respond to payment and clinical delivery innovations and monitor one entity for quality and compliance with contract standards. However, this model may make it difficult to keep up with changing definitions of primary and specialty care as well as changing service delivery systems, which may require repeated contract modifications or re-procurement. In particular, stakeholders expressed concern that the MBHO's freedom to set different credentialing standards or prior authorization requirements may adversely impact

Comment [c27]: The stakeholders per earlier comments "conceptually" support Model 1 but doubt that it can be achieved. The goal of the Department should be to craft a pathway toward Model 1.

Comment [c28]: Model 2 will be complicated and burdensome and complicating for consumers resulting in further division

Comment [c29]: Another potential pathway to a Model 1 truly integrated product, would be for department to mandate that all MCOs use one MBHO on ASO basis. And in turn mandate in RFP for MBHO that they co-locate staff with each MCO, data share in completely transparent fashion with MCOs.

Comment [c30]: The three largest MCOs have experience in providing specialty BH

Comment [c31]: The Department could contractually specify the BH expertise needed by the MCOs for Model 1.

Comment [c32]: Nothing in Model 1 prevents this from happening.

Comment [c33]: It is exactly this sole focus which is the problem with Model 2.

Comment [c34]: Except for somatic care data, which represents the significant majority of medical costs.

Comment [c35]: Providers may benefit but consumers will not see comment 44.

Comment [c36]: See comment 21 and 28

Comment [c37]: This can contractually addressed in Model 1- and is not a unique feature of Model 2.

Comment [c38]: See comment 21 Also note that Model 2, while touted as less administratively burdensome for providers, has the potential to be more administratively burdensome to consumers who will go to one entity for behavioral health and another for somatic care.

Comment [c39]: See comment 21

smaller/minority-run businesses that may struggle to adopt expensive practices.

A potential challenge under Model 2 would be the link between somatic and behavioral health care data for each individual. Separate data sources may make it easier to track performance and utilization data for behavioral health-specific issues. However, since consumers would still be receiving their somatic services through an MCO, the MCOs and the MBHO/ASO would need to coordinate so that data on the whole person is available to all entities and providers for the purpose of assessing clinical outcomes.

Comment [c40]: And a significant portion of complex somatic patients have co-occurring mental health/substance abuse disorders.

An appropriate cost allocation methodology would need to be established between the MBHO/ASO and the MCOs so that savings on either side due to improved outcomes would be seen by the appropriate entity. This may be a significant challenge, as there may be disputes over which entity is entitled to certain savings, as well as which entity is responsible for pre-authorizations and payments. Stakeholders were concerned that misalignment may reduce incentives for an MBHO/ASO to invest in certain interventions that create savings on the somatic side, particularly if the cost allocation is not done sufficiently. Separate entities may, however, make it easier to identify provider integrity or cost issues that are clearly on either the somatic or behavioral health side.

Comment [c41]: This is a significant issue particularly when you consider the need for real time data exchange. To cite just one example, AGP has asked the current vendor and MHA for mental health encounter data for five years and has yet to receive it.

Early identification and prevention was noted as a potential challenge under Model 1 due to the current focus on treating illnesses and preventing recurrence. There are also concerns about early identification and prevention under Model 2, but for a different reason. While a specialized entity may have the expertise for and resources to dedicate to early identification and prevention, it may be more difficult because individuals are receiving their somatic treatment through another entity. Individuals do not enter the MBHO/ASO until they require behavioral health services. As a result, coordination between the MBHO/ASO and MCOs is critical, as is training primary care providers to better identify and refer patients with significant behavioral health needs.

Comment [c42]: A huge issue- for example the MCO is managing a diabetic patient and is successful in stabilizing the diabetes and thereby reducing ER use and inpatient admits. The ASO MBHO is also managing the same patient who has a diagnosis of depression. The provider is also providing direct care to the same patient, and the patients primary care provider, based in a State sponsored medical home (to whom the MCO is paying a monthly admin fee to cover services beyond FFS) is also providing both direct services and medical home services to this patient.

So one patient and multiple providers and systems involved (MCO, ASO MBHO, mental health provider, MCO case manager, PCP, State sponsored-MCO paid medical home).

Who gets credit- who gets the \$ - for any improvement in healthcare outcomes?

We suggest Model 2 makes the development of 'a cost appropriate algorithm' impossible.

One of the biggest challenges stakeholders see under this model is the coordination of care for an individual for their somatic and behavioral health needs. Individuals with concomitant health conditions will be treated in two different systems. While this may result in better health outcomes because the different systems have more focused expertise, it may also lead to poorer health outcomes as consumers and their families navigate two systems of care. Similarly, it may be difficult to quantify consumer engagement across two systems of care as somatic and behavioral health interact through the lifespan. Some argue that this model does not represent true integration for these reasons. Under this model, particular attention would need to be paid to ensure behavioral health services are offered at parity with somatic services. The system would need to be sure to support integration efforts happening around the state that integrate somatic and behavioral health care at the clinical level.

Comment [c43]: In addition, the Departments decision to move from at-risk MBHO (proposed on 9.13.12 presented to stakeholders for feedback and discussion) to an ASO MBHO (contained in 10.1.2012 proposal submitted to Secretary) further undercuts the MBHO ASO incentive to coordinate care.

Comment [c44]: Department can address this concern in Model 1 by specifying standards in contract with MCO.

Comment [c45]: Per earlier statement, it appears that all stakeholders agreed that Model 2 is not true integration.

Model 3: Risk-Based Population Carve-Out (Newly Introduced in this Process)

As in Model 1, all Medicaid-financed behavioral health benefits and general somatic benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty managed care entity (SMCE) to manage the comprehensive benefit package for individuals with serious behavioral health disorders. That is, enrollment in the specialty health plan would be determined by whether the individual has a specified behavioral health diagnosis, such as serious and persistent mental illness. If such a diagnosis is present, the person would be enrolled in a specialty health plan, which would be required to deliver the full array of behavioral health and medical benefits. If such a diagnosis is not present, the person would be enrolled in a traditional MCO to receive his/her full array of behavioral health and general medical benefits.

Comment [c46]: The issue of true integration is less about parity, and is about a consumer centered system that via a detailed contract moves the State on a pathway toward true integration. The recommendation for Model 2 does not move in this direction.

Model 3 shares many of the benefits and challenges of Model 1, as the models are closely tied to one another. Under Model 3, all Medicaid-financed somatic and behavioral health services are provided under a SMCE for a specific population. Individuals who do not fit the criteria to have their services covered under the specialized entity will receive all services through MCOs, including behavioral health services. Instead of repeating the discussions that took place around Model 1, readers should keep those in mind as they read these additional points specifically regarding a SMCE.

Individuals with serious behavioral health needs may benefit significantly under Model 3. As the SMCE would focus on this population specifically, the delivery of services for this population may be more integrated and tailored to their unique needs. A specialized entity may be better at engaging consumers regarding their whole body health, and consumers may be more likely to access and follow-up with care, leading to better outcomes. Depending on the specifications, individuals may have access to continuous care over their lifetime, which could also drastically improve outcomes for this population.

The SMCE may find it easier to tailor performance targets for providers dealing with higher-need consumers, as opposed to an entity managing care across the continuum of need. In addition, a specialized entity for this population may mean more timely adjudication of claims and authorization data.

Early identification and prevention may be a challenge under Model 3, as individuals must be diagnosed with a high behavioral health need in order to have their services managed by the SMCE. Coordination between the SMCE and the MCOs would be necessary to ensure appropriate early identification and prevention.

Under Model 3, there is the potential for adverse selection as providers may be incented to diagnose consumers with moderate needs as consumers with severe needs to move them from the MCO into the SMCE (or vice versa). Similarly, there may be disincentives for patient recovery (or for the documentation of improved outcomes) from the SMCE in order to retain consumers. Such mis-labeling could harm consumers and significantly skew data on this population.

Churning between the SMCE and MCOs is a concern as consumers fluctuate on the behavioral health status continuum over their lifetime. If this model is adopted, individuals should be allowed to remain in the SMCE for a period of time (potentially for their lifetime) to enhance continuity of care. If the individuals transition between entities, there will need to be a high level of coordination because there will be two sets of somatic and behavioral health data for each person. Family continuity may be an issue under this model if some family members receive care through MCOs and others through the SMCE. While this model may be administratively efficient for the population with high behavioral health needs, these efficiencies may be lost if individual and/or family continuity is poor.

Stigma may be an issue under this model, as high-need consumers would be receiving care from a different entity. However, health plans providing care to the high-need behavioral health population could engage with consumer advocates to minimize any stigma that may be created by participating in the SMCE.

A specialized delivery system may be more adaptable to emerging innovative clinical practices as they have a smaller, more well-defined population for which to provide services. However, to ensure financial viability, payment rates would have to be carefully evaluated and reevaluated as the population included in the specialty group is redefined or churns into and out of the system.

Some concern was expressed for this Model from a budgetary standpoint. Though savings are anticipated on the somatic side for the adult population, they may be hard to demonstrate and are not expected for the child population. As an expensive program, as well as a program serving people very different from the general population, stakeholders raised the question of whether this program would survive budget cuts. It was pointed out that this model may be the best way to demonstrate cost-savings for this population and may, therefore, be the safest place for the care of high-need individuals.

The majority of stakeholders supported the concept of a population carve-out as it applied to a health home model, but did not support this model as the new, statewide financing mechanism for Medicaid behavioral health services.

Recommendation

After considering all input, and after comparing all three models against the eleven criteria and seven guiding principles, the Steering Committee recommends Model 2, a specialty behavioral health carve-out. The Steering Committee recommends that the carve-out operate using an administrative services organization (ASO), with significant and meaningful performance risk at the ASO and behavioral health provider levels.

The basis for the recommendation follows:

1. Model 2: Behavioral Health Carve-Out

Model 2 offers important advantages over the other models.

Covers All Medicaid Eligibles. Only Model 2 reaches all current Medicaid beneficiaries—including HealthChoice enrollees, Medicare-Medicaid dual eligibles, individuals in REM, and those individuals in long-term care who are not dual eligibles. Because 20 percent of the individuals enrolled in Medicaid who have a behavioral health diagnosis are not members of MCOs, and both Model 1 and Model 3 rely on integrating behavioral health services into MCOs, these models would be unable to reach all Medicaid beneficiaries.

Reduces Burden on Providers. Currently, there are seven HealthChoice MCOs, with four additional MCO applicants seeking to enter the HealthChoice program by January 2014. In Model 1 or Model 3, if the Department did not require the adoption of uniform approaches across all MCOs, each MCO could establish its own standards (directly, or through a subcontracted behavioral health organization (BHO)) regarding behavioral health provider credentialing, prior authorization, utilization review, payment rates, and contracting practices. All of these MCO-developed policies and procedures would create substantial administrative costs and burdens for behavioral health providers, and would direct financing away from behavioral health care and toward administrative activities. On the other hand, if Model 1 or Model 3 was selected, and the Department sought to reduce this administrative burden by requiring each MCO to use the same BHO (which would be a BHO independently selected by the Department), we would have a model that is structurally identical to Model 2.

Adaptable when Somatic Programs Change. On the somatic side, Medicaid is likely to see changes in the future, as new MCOs join HealthChoice (and also as MCOs' service areas periodically change). Moreover, Medicaid is likely to see changes as the Department eventually pursues one or more initiatives to integrate care for Medicaid-Medicare dual eligibles. Model 2 would allow Medicaid to pursue these changes without needing to change the basic structure for the delivery of behavioral health benefits. This is depicted on the left-hand side of Illustration 1 below, whereby each MCO or fee-for-service program could link to the Model 2 entity.

Comment [c47]: The Department expresses significant concern about this issue. What is the size of the population that will not be served under HealthChoice in 2014? What is the size of population under HealthChoice in 2014? What are the corresponding SA and MH \$ for both populations?

Comment [c48]: See comment 58

Comment [c49]: See comment 58

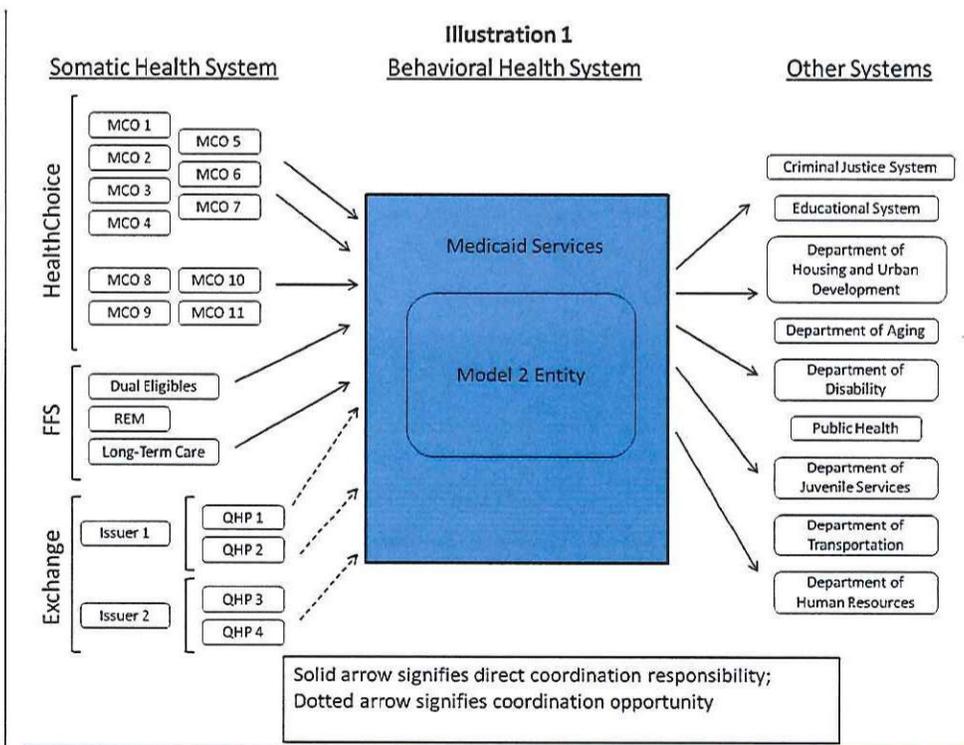
Comment [c50]: So why, in Model 1, doesn't the Department adopt uniform approaches (i.e. credentialing, auth, fee schedules, etc)? It has done so successfully for the current substance abuse benefit.

Comment [c51]: This could be accomplished by either requiring same BHO, or standardizing processes, or mandating creation of common front door website for all BH related transactions that all MCOs would use.

Comment [c52]: See comment 54

Comment [c53]: Department could require that MCOs offer dual eligible product(s) if/when Department moves in that direction

Deleted: ¶



□

Adaptable when demographic factors change. One of the trends expected in the next several years is an increase in the rate at which individuals will shift from “Medicaid-only” status to Medicaid-Medicare dual eligible status as more Medicaid eligibles turn 65 (along with the rest of the baby boom wave). Medicaid-Medicare dual eligibles do not receive somatic services through MCOs but, rather, primarily through Medicare and secondarily through Medicaid FFS. In addition, Maryland disenrolls anyone who turns 65 from HealthChoice. Under Models 1 or 3, as is true with somatic care, people would be forced to leave their MCO-delivered behavioral health system and provider when they are required to disenroll from their MCO upon becoming eligible for Medicare and converting into dual eligible status. Model 2 would eliminate this transition, and allow an individual to stay with his/her ASO to access behavioral health services after he/she becomes a Medicaid-Medicare dual eligible, or otherwise transitions into/out of managed care.

Comment [c54]: This diagram can easily be adapted to fit Model 1. For example, the Department could create a Behavioral Health Coordinating Committee – chaired by State Department of Behavioral Health- and made up of all the systems surrounding the blue box. This Committee would address the many of the issues identified in this section as favoring Model 2.

Comment [c55]: See comment 54

Relationship to Non-Medical Systems. Individuals with significant behavioral health needs often are involved in non-medical public systems, including schools, housing, employment, criminal justice, and others. A single contract with a Model 2 entity would create a single point of accountability and coordination to link Medicaid-financed behavioral health services with these other public agencies, programs, and services. In other words, Model 2 best integrates the Medicaid-financed behavioral health benefits in treatment for mental illness and substance use disorders with other systems in which consumers frequently are involved. Both Model 1 and Model 3 would create multiple points of contact, communication, and coordination between behavioral health medical care and these other systems. While this is not an insurmountable challenge, and while the MCOs currently navigate many systems, these points of contact are reduced in Model 2. This is illustrated on the right-hand side of Illustration 1, above.

Comment [c56]: See comment 54

Comment [c57]: See comment 54

Eligibility “Churn”. The data show that 44 percent of the individuals in Medicaid who have a behavioral health diagnosis are in a poverty-related Medicaid eligibility category. Put differently, even though these individuals require specialty mental health services, they are not eligible for Medicaid by virtue of disability, but rather are eligible for Medicaid by virtue of poverty. A report published in Health Affairs in 2011 estimated that approximately 35 percent of all adults with incomes below 200 percent of the FPL will experience a change in income that causes them to move above or below 138 percent of the FPL (i.e. causes churn between Medicaid and the Exchange) within six months, and 50 percent will experience this churn within a year.² This is relevant to the behavioral health integration recommendation because Model 2 best coordinates the transition of individuals between Medicaid and Exchange-offered qualified health plans (QHPs) as a single point of transition for specialty mental health services. Models 1 and 3 would require many additional points of contact for these transitions between MCOs and QHPs. This is also depicted on Illustration 1.

Comment [c58]: See comment 54- where QHP would be part of Coordinating Committee

² Sommers, Benjamin D. and Sara Rosenbaum. Issues in Health Reform: How Changes in Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. Health Affairs. February 2011. vol. 30 no. 2 228-236.

³ Beginning in January 2014, children in foster care will be allowed to stay in Medicaid until they turn 26, under an optional provision of the ACA that Maryland will implement.

Relationship to Exchange (In Addition to Churn). Under federal law, QHPs must deliver “essential health benefits”, which will include an array of behavioral health benefits, offered in compliance with mental health parity laws. Even with parity, however, the QHP benefit designs nevertheless will be smaller, overall, than Medicaid’s benefit package. Model 2 would offer a single point of contact for QHPs for transitions that will arise not only when household income changes, but also when children in households between 138 – 300 percent FPL age-out of Medicaid and CHIP eligibility and become adults, thereby moving from Medicaid to the Exchange.³ A carve-out managed by a single entity is likely to facilitate these transitions of care more smoothly.

Comment [c59]: Comment 54

Relationship to State and Local Wraparound Benefits/Grants. Related to the circumstances under which a person might transition from Medicaid to a QHP and begin to receive a smaller overall behavioral health benefit package through the QHP, various state and local health care grants might serve to provide wraparound specialty behavioral health benefits to address needs for high-needs adults above 138 percent FPL. For example, certain mental health residential programs, or locally-administered substance abuse treatment grants, might supplement the

Comment [c60]: Comment 54

benefits delivered by the QHPs. When this situation arises, it is likely to be a smoother transition when the transition into state and local wraparound programs is handled by a single ASO that is coordinating with the state and local health departments and CSAs.

☐ **Relationship to Other Forms of Commercial Insurance.** A specialty behavioral health carve-out, managed by a single independent entity, might be an attractive entity for contractual relationships with commercial insurance carriers, in order to deliver any behavioral health benefits in the Exchange.

Comment [c61]: Comment 54

2. Risk

The Department's Steering Committee recommends the version of Model 2 that would utilize an ASO with performance risk. The Steering Committee supports this version of Model 2 for the reasons mentioned here:

Comment [c62]: Significant change from version presented to stakeholders on 9.1.32012. Shift from risk to ASO will undercut BHO incentive to coordinate care with MCO. We currently experience this with mental health ASO. Two weeks ago Department favored at-risk BHO, what happened to the reasons supporting at-risk?

☐ **Aligns Incentives.** An ASO model conceptually is capable of the transformative change that is required in Maryland. An ASO model could reward the ASO for strong outcomes, and similarly reward behavioral health providers who achieve positive health outcomes for their consumers. An ASO model could incorporate shared savings across systems (between MCOs and the ASO) and shared savings with providers (primary care providers and specialty behavioral health providers). An ASO model could also incorporate non-financial tools that distinguish providers who achieve positive outcomes from providers who achieve average or poor outcomes, including tools such as differential rules for prior authorization, utilization review, whether the provider is allowed to receive new consumers, and whether consumers may self-refer to the provider. In short, an ASO with performance risk up and down the system could generate many of the benefits of an insurance-based MBHO model.

☐ **Transition.** In order to execute the carve-out, all systems will need to adapt: substance use providers will be organized around a carve-out; a new procurement for behavioral health services in the new ASO will be necessary; new regulations and rates will be needed (including for the MCOs); and various federal approvals will be required. Because the Department simultaneously is managing a series of separate but related transitions that affect the behavioral health system, including a reorganization at the Department and the alignment of programmatic rules and regulations in mental health and substance use treatment, an incremental approach is called for here. That is, given all these changes, the Steering Committee thinks a more appropriate transition could be achieved with an ASO.

Comment [c63]: The recommendation for Model 2 ASO is incremental approach, but wrong directionally. It is moving further away from true integration.

The Steering Committee's recommendation for a performance-risk ASO, rather than a capitated MBHO, reflects its determination that Maryland's behavioral health delivery system is ready to embrace transformation premised on pay-for-performance, outcomes, and value-based purchasing. If other policymakers agree, then Maryland could move forward into Phase 3 to specify the framework for this transformation in an ASO model.

If, however, the Steering Committee's confidence is misplaced, and if the behavioral health system instead seeks to protect a more traditional fee-for-service model for an ASO that rewards volume over value, then Maryland's willingness to consider a performance-based ASO might need to be abandoned even before it starts. Absent a broad stakeholder willingness to embrace change that improves integration and outcomes within an ASO model, Maryland might need to immediately pursue moving toward an insurance-based MBHO model.

If Maryland moves forward with an ASO model with performance risk, the next phase, regarding the development of the specifications, could begin later in 2012 or early in 2013. (The one exception: Maryland will continue to expeditiously move forward with the implementation of the "Health Home" option under Section 2703 of the Affordable Care Act.) Beginning the specification development on this timeline could result in the implementation of the new model during calendar year 2014.

3. Application of Criteria

Eleven criteria were established at the beginning of this process to guide the selection of a

Comment [c64]: See comment 54- All reasons cited in this section for choice of Model 2 can be addressed in well designed Model 1.

financing model (these criteria can be found as Appendix VII to this report). The advantages that have been put forth in this report demonstrate that Model 2 best ensures the fulfillment of these criteria.

The reduced burden on providers, in combination with flexibility around financing and benefit design, would ensure the right providers are accessible in the right place at the right time, and that the right services are provided. In addition, an entity solely responsible for behavioral health services would be in the best position to design authorization requirements, incentives, and other mechanisms that best fit the abilities of behavioral health providers and meet the needs of the behavioral health population. For this reason, Model 2 would also best ensure positive health outcomes specifically in behavioral health, in particular for those individuals with chronic behavioral health conditions. This model may present challenges on the somatic side, which are addressed later in this report. A single entity managing care for all behavioral health services may allow for richer data and measures to be collected and accessed quicker and easier than under either Models 1 or 3.

Comment [c65]: Only true of behavioral health measures. The collection and integration of somatic data will present additional challenges in Model 2.

Housing all behavioral health services for all people under a single entity, an entity that could possibly provide services for Medicaid beneficiaries, dual eligibles, Exchange enrollees, and commercial insurance consumers alike, would best ensure care across the lifespan and as individuals' needs and program eligibility changes. It would also best ensure that the system is adaptable over time, as the ASO would have significant flexibility and would be impervious to changes that may occur on the somatic side. This may also reduce administrative burden and make providing behavioral health services more cost effective than a system under which multiple entities manage and finance these and other services.

4. Review of Integration Principles

In his cover letter to the 2011 Consultant Report, Secretary Sharfstein outlined seven principles to guide future integration work. The Steering Committee is convinced that the advantages that have been put forth in this report demonstrate that Model 2 best upholds these principles.

All of the models being considered during this process integrate financing for substance abuse and mental health treatment services. By ensuring delivery of the right services in the right place and time by the right practitioner, Model 2 would provide the greatest value to Marylanders. It would also support effective models of integrated care and be able to coordinate with other systems through strong, established linkages with non-medical systems and by caring for individuals across their lifespan and as needs and program eligibility changes.

An entity solely focused on behavioral health services, with demonstrated expertise with this population, would be able to best care for the needs of the seriously ill. A capitated entity would have the flexibility to provide payment on the basis of performance, value, and outcomes, and would have the direct relationships with providers necessary to ensure strong oversight and engagement. The data collected would likely be more comprehensive, timely, and accessible than it would have been under either Models 1 or 3 and, thus, would be very helpful to localities when caring for their residents.

Comment [c66]: But the recommendation is not for a capitated model 2 but rather an ASO model 2...why?

5. Challenges in Model 2

Model 2 clearly is not perfect. Model 1 and Model 3 offered advantages that do not exist in Model 2, and addressing the limitations and challenges in Model 2 will be a crucial element in the next phase of this effort. These challenges that must be addressed include:

☑ Care coordination. One of the major challenges with Model 2 involves the lack of direct integration between somatic care (including primary care) and specialty behavioral health services. The Department will need to address this, potentially by formalizing care coordination between the ASO and MCOs in structural ways that do not exist under the current model (with the MCOs and current ASO). For example, a possible model is found in Michigan, where both systems are required to designate a care coordinator for all beneficiaries served in the specialty mental health system, and the respective care coordinators must regularly meet to discuss the beneficiaries they mutually serve. This would create a form of "care bridge" (in the language of Michigan) or cross-system treatment team approach.

Comment [c67]: Double care coordination costs..and the experience of these "care bridges" in past has not been good. Why not via the contract process create an integrated care coordination process within the MCO- and build the 'care coordination bridge' at the system level (see comment 58).

☐ **Payment disputes.** Adopting Model 2 would require developing an approach to address billing disputes between the services managed by the ASO and MCOs. For example, Maryland's hospital payment system requires that a single entity pay an entire hospital bill – the Health Services Cost Review Commission (HSCRC), which regulates hospital payments, prohibits so-called “split billing” whereby a single bill is split across different payers. As a result, payment disputes are likely to arise between the two systems.

Comment [c68]: This is a problem created by model 2- endless permutations make solving this a significant challenge, and it also creates perverse incentive for either system to push consumer to other side of system. Not in the best interest of consumers.

Comment [c69]: Payment disputes will arise

☐ **Shared savings.** In Models 1 and 3, all costs and savings are located within the same overall organization. This more easily encourages the delivery of preventive services where the costs are incurred in one system while the savings are experienced in the other system: for example when community-based mental health treatment avoids the use of emergency rooms, or when a primary care provider helps to keep someone from developing a debilitating addiction. This form of cross-system shared savings is not naturally present in Model 2.

Comment [c70]: In fact, not only are the financial incentives not aligned in model 2, in many instances, particularly in ASO model, they will be diametrically opposed. For example, the administrative BHO has no incentive to coordinate care with the MCO because to do so will cost more administratively and may well end up costing their customer (the State) more in behavioral health costs.

☐ **Common data platform.** In Models 1 and 3, real-time care delivery data is easier to share across systems and providers – information on prescription drug use, emergency room visits, inpatient admissions, etc. Because all providers might be enrolled with a single overall MCO in both Models 1 and 3, this is simpler in those models. Model 2 does not lend itself to such a straight-forward approach to clinical data sharing across systems and providers.

Next Steps

Despite the great work that has been done, the process is far from over. Over the next 30 days - by November 1, 2012 -- the Department would like to receive public comments on this recommendation.

Following review of those comments, Secretary Sharfstein will determine whether to proceed with the recommendation found in this report. If so, the Department will notify all stakeholders (and the Legislature), and we will proceed into Phase 3, because the recommendation in this report does not require legislation.

If, after reviewing the comments, Secretary Sharfstein thinks that an alternative direction should be pursued, one in which legislation would be required, Secretary Sharfstein and the Department would begin working with key legislators and policymakers to prepare for the 2013 legislative session, and would continue working with stakeholders to pursue an alternative model.

If the Department moves into Phase 3, which will involve developing specifications for the new system, then we would work with stakeholders to address issues, such as:

Comment [c71]: All these issues could also be addressed in Model 1

- **Financial incentives.** To make the ASO model truly transformative, performance incentives and measures need to be established, including the structure of pay-for-performance at the ASO and behavioral health provider levels, such as shared savings. Also, the State would need to define the metrics for these payment arrangements, and ensure the data is objective and available.

- **Evaluate mechanisms to encourage shared savings and coordination between the ASO and the MCOs.** The specifications will need to determine whether and how to align financial incentives across the systems. This is a complex undertaking that requires reviewing the total cost of care, on a risk-adjusted basis, and comparing expected trends against baseline data. Still, if this is possible, it would better align incentives, so that, for example, savings generated by the ASO and behavioral health providers that might reduce somatic costs (e.g. avoided emergency room visits and inpatient admissions) could be shared.

Comment [c72]: See comment 42. Model 2 creates this problem for which there is no easy algorithm.

- **Mechanisms for care coordination.** The specifications will need to address care coordination, potentially by formalizing care coordination arrangements between the ASO and MCOs in a structural manner. For example, the Department could require all MCOs to designate a care coordinator for all beneficiaries served in the specialty mental health system (or, possibly, more narrowly in a Chronic Health Home) who would coordinate with the beneficiary's care coordinator/case manager in the specialty behavioral health system. Further, the Department could require that the respective care coordinators regularly meet to discuss the beneficiaries they mutually serve.

Comment [c73]: Double admin costs

- **Establish authorization rules.** The Department will need to establish prior authorization and

utilization review rules that the ASO will execute. Moreover, in adopting non-financial incentives to drive value, the Department would need to consider when, if ever, the ASO might be authorized to exempt a provider who drives positive outcomes from prior authorization and utilization review requirements imposed on other providers.

- Quality measures and reports (that could also involve performance incentives/sanctions). The Department will need to identify the performance measures for conducting oversight of the ASO contract. Potential measures could include beneficiary and provider satisfaction, access/utilization rates, HEDIS scores, avoidable emergency room visits with an underlying behavioral health origin, unnecessary readmission rates (including to hospitals in the MCO benefit package), and others. The Department also would need to determine what portion of the overall financing to place at risk for the ASO and providers.

- Mechanisms to address billing disputes. As previously mentioned, one challenge in Model 2 is the presence of billing disputes between the services managed by the ASO and MCOs. The specifications could help to address this by, for example, requiring the ASO to have a contract (or Memorandum of Understanding) that establishes the personnel (at each organization) and process to resolve disputes with each MCO before bringing the problems to the Department for resolution. The specifications also should establish, more clearly, how to address these disputes, which typically involve hospital payments.

- Related MCO specifications. In addition to the other MCO-related issues mentioned elsewhere, the Department would need to consider where and how to change the specifications of the MCO system, potentially to include these issues: (a) a requirement that the MCO have policies to contract with primary care providers that are embedded within Chronic Health Homes, based on criteria that would be set by the Department; (b) that Medicaid's definition of a "Patient-Centered Medical Home" includes behavioral health identification, treatment, and referral; and (c) that each MCO designate its administrative lead for all issues related to the ASO (and this person would oversee the care coordination, billing disputes, and other issues).

- Data Sharing. The specifications must address the approach to share clinical data between the ASO and MCOs, and between providers. The Department's strategy to increase bi-directional data sharing between the MCOs and the ASO to improve beneficiary care, which could include an approach that aligns electronic health records, must be addressed in the specifications.

- Beneficiary protections. The Department could specify certain kinds of beneficiary protections. For example, the State could compel the ASO to organize a beneficiary "advisory council", a beneficiary "Ombudsman", and similar requirements. The Department could also require additional protections regarding issues like a guaranteed right to a second opinion in certain circumstances, the operation of a beneficiary call center at the ASO, and a robust grievance and appeals system.

In Phase 3, the Department will also work to ensure the federal parity legislation is applicable to the new financing model and that all behavioral health services are offered at parity with somatic services.

Moving forward, the Department will determine a timeline to best implement this model such that it is the most effective for and the least disruptive to consumers, providers, and managing entities. The Department will ensure that all stakeholders have the right tools and ample time to prepare for transitions. Integrating mental health and substance use under one roof is the first priority of the Department, both at the administrative level and the financing and management level.

After the report has been thoughtfully considered, and final decisions have been made at the Department, we will notify stakeholders as to how to participate in Phase 3 and other future integration efforts. The Department would like to thank stakeholders for their contributions. We urge stakeholders to remain engaged to help ensure that integration is affordable and practicable for providers, cost-effective and manageable for payers, and most importantly, improves outcomes, lower costs, and creates a better consumer experience for all Marylanders.