



Community Health Integrated Partnership
Maryland Community Health System

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Comments on “Future Options for Integrated Behavioral Healthcare”
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The Maryland Community Health System and Community Health Integrated Partnership appreciate the opportunity to submit written comments on the draft report entitled “Future Options for Integrated Behavioral Health Care.” As organizations of federally qualified health centers (FQHCs), we are committed to working with the Department of Health and Mental Hygiene (DHMH) and other stakeholders to designing a patient-centered system of care. We believe that the optimal system would integrate benefits management, reimbursement, credentialing, and clinical services for both behavioral health and somatic care. This integrated system would produce the best patient outcomes and would be the easiest for patients and their providers to navigate.

This report contains many of the elements needed by policy-makers to move forward in identifying pathways for an integrated system. We would like to note that it would have been beneficial to have the information in the report earlier in the process. We think that the public discussion would have been more structured and productive with this type of information. We are looking forward to participating in ongoing discussions about integration.

Major Policy Issues from the FQHC Perspective

In reviewing the report, we identified the following three major areas for FQHCs on which we would like to comment.

Coverage Parity for Behavioral Health Services

FQHCs are in full support for ensuring that there is parity between behavioral health and somatic services coverage. Our health centers are on the front-lines in delivering care to individuals with co-occurring disorders. We understand that the health of our patients depends on having the full-range of services.

We think that it would be helpful for the report to include an expanded discussion about parity. It is essential for policy-makers to have an in-depth understanding of the parity issue in order to design the coverage systems in both Medicaid and the Health Benefit Exchange.

We would like to note that the report makes two incorrect assumptions about parity:

- On page 6, the report states that, “any mandate for behavioral health services will expand the availability of MH/SUD treatment, especially for those who have depended on public systems and providers.” Without knowing the federal requirements for essential health benefits, we

do not think we can make this assumption. In fact, there is great concern amongst advocates that the federal requirements may not achieve parity; and

- On page 7, the report makes a similar assumption that “Adherence to parity requirements will also create access to health insurance coverage for individuals who rely on publicly-subsidized treatment.” Maryland has a good track record of supporting treatment for individuals on Medicaid and in the “grey zone.” Without knowing the federal requirements of the essential benefits package and how many uninsured individuals will actually enroll in Exchange programs, we feel that it is difficult to make assumptions about access.

FQHCs Deliver Specialty Behavioral Health Services

The report discusses two types of delivery platforms on pages 21-22: community behavioral health organizations and primary care practices. We believe that both types of organizations are important in the delivery system. To understand how the system functions, we think it is essential to capture the full range of behavioral health services that some primary care practices offer. The report seems to assume that primary care practices only deliver behavioral health services through primary care practitioners. However, many of our FQHCs deliver a full range of services through behavioral health practitioners. Thus, the description of primary care practices should acknowledge that some practices, such as FQHCs, have the same elements as community behavioral health organizations. For example, the report describes community behavioral health organizations as employing “a mix of licensed professionals, paraprofessionals, and peer specialists”. However, the description of primary care practices only refers to primary care practitioners.

We would also like to suggest that it would be helpful for policy-makers to further explore how community behavioral health organizations and primary care practices work together in different communities. In some communities, primary care practices, such as FQHCs, may offer a fuller range of behavioral health services because of that particular community's needs. In other communities, FQHCs may not provide the full range of services because it has a strong partnership with a community behavioral health organization. Both models have been successful, and it would be helpful to identify the important elements that have contributed to that success.

More Work Needed on Options for Integrated Health Benefits Management

We think this report offers a start in thinking about the options for integrated care. However, we think that policy-makers may require three additional elements to make any decisions:

- **Defining the question of “What does integration mean?”:** This report uses two meanings of “integrated care”, making it difficult to determine what is DHMH’s ultimate goal. Integrated care could have one of two meanings: 1) the integration of different types of behavioral health services, including mental health and substance use services; or 2) the integration of behavioral health and somatic care services. The report uses these two meaning interchangeably, even though these meanings have profoundly different implications. Therefore, it is difficult to discern if DHMH’s goal is to integrate mental health and substance use services or to integrate all behavioral health services and

somatic care. Without a clearer understanding of this goal, it is difficult to evaluate which of the options on pages 25-27 is preferable.

If DHMH's goal is just to integrate mental health and substance use services at this time, then we believe that the risk-based behavioral health plan(s) in Option 2 may be a reasonable option for DHMH. By focusing on behavioral health coverage, these plans may be in a good position to ensure consistency in coverage, reimbursement, and provider credentialing for mental health and substance use services. However, as providers of both somatic and behavioral health care, we think that DHMH's long-term goal should be to integrate all types of health care services. Option 2 likely does not offer the best long-term solution as there are so many issues related to coordination of benefits and services for somatic and behavioral health.

If DHMH's goal is to integrate behavioral health services and somatic care, then Option 1 with fully integrated coverage through Managed Care Organizations (MCOs) may be the best option for DHMH. We note that there should be consideration of whether MCOs will be able to provide the necessary focus on behavioral health services. In considering Option 2, DHMH should consider what tools both DHMH and MCOs would need in order to ensure patients received the appropriate level and type of behavioral health services.

- **Supporting Integration at the Provider and Consumer Levels:** The report does not discuss how Options 1 and 2 would support the integration of clinical services at the provider and consumer levels. We think that it is essential that policy-makers have this information when making decisions. Therefore, we think the report should be expanded to include discussion of important questions, such as: how can a risk-based behavioral health plan ensure that a provider or providers coordinates somatic and behavioral health services; with an MCO model, do separate capitated rates for behavioral health and somatic health services make sense or will they perpetuate barriers to integration at the provider level; and will a consumer with behavioral health needs have a better experience with separate plans for behavioral health and somatic services or would it be easier to navigate the delivery system with a single plan?
- **Including Perspectives from Stakeholders on Specific Issues:** The consultant's focus groups elicited general observations from both providers and consumer advocates. However, we think additional public discussion using a structured process would yield more concrete recommendations from stakeholders and ultimately would be beneficial to policy makers. For example, we think it is important to capture stakeholder's perspective on how to integrate mental health and substance use services workforce, how either an MCO or behavioral health plan can promote greater coordination amongst different providers, and how consumers can navigate services in an MCO or behavioral health plan model. Although integration is a top priority of DHMH's and our organizations as well, we believe that it is worth the time to have some additional structured public discourse.

Other Policy Considerations

We appreciate the breadth of issues that this report covers. We have suggestions regarding several policy areas it would be helpful to have clarification or more information:

- **Patient-Centered Medical Homes and Health Homes (pages 7-9):** We think it would be helpful to consider how patient-centered care improves health outcomes. While it is implied in the report, more information is needed. For example, how can health outcomes be improved if a patient receives integrated behavioral health services from a single provider? Or what is the impact on chronic somatic illnesses if care is provided in a single setting? We note that this discussion will help define whether DHMH's goal is to integrate different types of behavioral health services or to integrate somatic and behavioral health services (Please see our earlier discussion on this topic);
- **NCQA Accreditation (page 9):** We suggest that the report note that the statistics demonstrate NCQA accreditation for FQHCs nationwide rather than just in Maryland;
- **Discussion of DHMH Accreditation Work:** It would be useful to provide a description of DHMH's work on accreditation of behavioral health providers, as regulatory issues have created barriers to integration of services at a provider level;
- **Defining Selective Contracting (page 23):** The report makes a number of references to selective contracting or active purchasing. Although Medicaid is exploring this issue as relates to the current managed care system, we think it would be helpful to understand what selective contracting means for risk-based behavioral health coverage whether through MCOs or behavioral health plans;
- **Importance of Quality Incentives (page 23):** The report specifies that establishing "incentives to promote efficiency" should be a principle of promoting integrated care. We agree with this principle and would suggest expanding it to include incentives for quality care; and
- **A Single or Multiple Behavioral Health Plan?:** We note that the some sections of the report promote that there be a single behavioral health plan, such as the discussion of "selectively contracting with a behavioral health plan" under "Benefits Management" on page 23 and having "all components of the publicly insured behavioral health benefit managed by the same entity" under "Principles for Promoting Integrated Care" on page 23. However, on page 25 under Option 1, the report indicates that there could be multiple behavioral health plans. We would suggest that the report be consistent in reference a single or multiple behavioral health plan options as well as discussion of the implications of a single vs. multiple behavioral health plans;

Conclusion

Thank you for the opportunity to comment on this report. We are committed to continuing to contribute to DHMH's efforts. For further information, please contact Ms. Salliann Alborn, CEO of Maryland Community Health System/Community Health Integrated Partnership, at salborn@chipmd.org or Ms. Robyn Elliott, legislative representative of the Maryland Community Health System, at relliott@policypartners.net.