

Magellan Health Services

Please find attached the comment submission from Magellan Health Services with regards to the Maryland Department of Health and Mental Hygiene “Integrated Behavioral Healthcare: Possible Options” draft paper and subsequent consultants’ report entitled “Future Options for Integrated Behavioral Health Care.” Magellan Health Services is a specialty care management company with consistent focus on public sector, behavioral and health and wellness as legacy strengths. In the behavioral health (BH) arena we are the leading provider of care for over 31 million members through management for health plans, government, and employers.

Through our BH management, Magellan provides clinical expertise to a variety of populations including the seriously mentally ill (SMI), dual eligible (i.e. eligible for both Medicare and Medicaid), and Age, Blind, and Disabled (ABD) populations. In addition, Magellan also has established Integrated Health Homes in combination with State submissions under the provisions of 2703 or the ACA in Arizona and Iowa where the behavioral health provider is the “home” with support from Magellan, physical health provider and home and community based services. In Arizona, Magellan cares for 700,000 beneficiaries, of which 70,000 are high utilizers of BH services (i.e. SMI diagnosis). In both of these initiatives, we employ clinical guidelines combining SMI with co-morbid medical conditions, new risk stratification methodology, integrated health risk assessments, a whole health integrated service plan, and various Medicaid engagement strategies.

While we recognize that the “options” paper and subsequent recommendations are merely a guidepost to inform the State’s thinking, we do have some observations and recommendations and appreciate the opportunity to share them with you.

With regard to the broad recommendations that:

- “There should be a singular behavioral health benefit package that includes both mental health and substance use disorder services
- The public behavioral health benefit should be managed through the same entity, using compatible utilization management criteria, a consistent care management approach, identical medical necessity criteria and the same level/type of utilization management staff members who possess experience and credentials that demonstrate understanding of the organic, social and psychological dimensions of the many types of addictive and psychiatric disorders. (Note: The public behavioral health benefit includes services financed by both Medicaid and indigent care funds)

Separating mental health and substance use disorder services and benefits management is neither an efficient nor clinically effective way to rationalize access or support outcomes.” We concur.

However the specific options outlined give us reason to comment.

Option 1 - By 2014 have at least the Medicaid behavioral health benefit managed by Health Plans through a “protected carve-in”.

As a company that has worked collaboratively with and as behavioral health subcontractor to health plans across the company for more than two decades, we

understand this approach and have done so with more than 1.5 Million Medicaid members. While we are not opposed to this approach generally, we offer cautions in several areas, for specific populations.

1. Health Plans historically have little or no experience in dealing with non-Medicaid supported services funded through Federal Block Grants and State general funds. These are services that are frequently not included in Medicaid benefit packages and bring with them specific federal reporting requirements that differ.
2. Similarly, health plans do not typically have the internal capacity to serve those with severe disabilities, including those with serious mental illness. We would direct your attention to other States like IL where there have been difficulties identified by the advocacy and stakeholder communities as the Aged, Blind, Disabled populations were included in traditional management care programs. Of particular note is the consultant's statement regarding this option: "It allows the State to test Health Plans' assertion that they can manage behavioral health as effectively as they manage general medical care. It also allows the State to place risk for both general health and behavioral health outcomes in one management system (assuming this would be a contractual expectation) and would have providers participating in one integrated network." (emphasis added) First, it would be a significant risk to both individuals and potential costs to simply "test" this hypothesis. Second, the original recommendations included a prohibition from a health plan utilizing the services and expertise of a specialty behavioral health organization through a subcontract. This misses the point in two respects. 1) most large health plans subcontract with their own subsidiaries or affiliates, so there is no administrative cost efficiency or administrative "integration". Second, specialty BHOs paired with health plans bring the best of both organization's strengths - expertise, infrastructure, and service. Should the State move in this direction, it is essential that health plans competition not be limited by with whom they partner to bring what is needed to support the delivery of truly integrated services - which happens at the practice level, not the vendor contract level.
3. There is also reference to "reinvestment" through savings. Only BHOs have a track record of achieving this.

Option 2 - By 2014 have the Medicaid behavioral health benefit and the State/block grant-funded benefit package managed through a risk contract with one or more Behavioral Health Plan (BHP).

1. Moving this program to full risk is best practice and wise in terms of expanding the benefit at no cost to the State.
2. Other States have successfully utilized a BH specialty managed care approach to improve clinical care and contain costs. Iowa, Massachusetts, Nebraska, Pennsylvania and Arizona are examples that have a multi-year record of accomplishment in increasing access to care, expanding the array of community-based services and containing costs for services with persons with serious mental illnesses, individuals with addictive disorders, children with serious emotional disturbances and persons with co-occurring, chronic disorders. All of these States include both Medicaid and Non-Medicaid funds. Common elements of all these specialty plans include a competitive bidding

process, use of capitation or other risk bearing rate setting, standards of care for people with serious and chronic conditions and limits on administrative costs. The gross cost of care savings for BH specialty managed care approaches in similar state Medicaid programs typically approach 20% during year two of the contract and 10-15% in ongoing trend reductions in future years. These specialty programs typically provide improvements in a range of quality metrics, including reduced readmissions to high end and inpatient care, decreased inpatient length of stay, decreased residential treatment and provided better access to care.

3. We also believe that disadvantages to this option identified by the consultants are overstated. “While this approach has the advantage of relying on behavioral health-experienced organizations and passing insurance risk to a behavioral health plan, it has significant disadvantages: 1) it’s a first-generation approach to managing behavioral health, most often used in its purest form in the early 1990s when States began the use of risk arrangement for behavioral health; 2) it does not lodge accountability for both medical and behavioral benefits in the same management system; 3) in some sense, it requires workarounds to build incentives for integration externally; 4) it requires that the State align two separate contracts and contracting processes as part of these workarounds; and 5) it’s an interim step to integrating financing and benefits management in support of integration of clinical treatment”. Louisiana, Virginia and Idaho have moved in the past year or have immediate plans in the next year to move behavioral health carve-outs, so the statement “first generation”, is not supported. Models such as we are implementing in AZ and IA do demonstrate that the services can be integrated and the accountability can be through a single vendor for special populations and not a “interim step” if it is designed as an integral part of the design.

We appreciate the opportunity to comment and would be happy to provide additional context to our comments through additional communications or in-person with the appropriate DHMH staff.