



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

DEC 27 2011

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2011 Joint Chairmen's Report (p. 68 – M00K01.01) – Progress Update on Behavioral Health Integration

Dear Chairmen Kasemeyer and Conway:

In keeping with the requirements of the 2011 Joint Chairmen's Report (p. 68), the Department is submitting the enclosed report on behavioral health integration.

For further information, please contact Marie Grant, Director of the Office of Governmental Affairs, at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Tom Cargiulo
Patrick Dooley
Renata Henry
Brian Hepburn
Chuck Milligan
Marie Grant



M00K01.01

Department of Health and Mental Hygiene

Behavioral Health Integration – Progress Update

As part of the FY 2012 budget, the General Assembly asked the Department of Health and Mental Hygiene to convene a workgroup “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues.” The General Assembly asked the Department to provide recommendations for developing such a system. This report is in response to that requirement.

In making this request, the General Assembly recognized the current lack of coherence in Maryland’s approach to patients with behavioral health conditions. Many individuals with mental illness also suffer from addiction, and large numbers of individuals with addiction have mental illness. The Substance Abuse and Mental Health Services Administration estimates that only 7.4 percent of individuals in the United States with co-occurring disorders are treated for both conditions; more than half do not receive treatment for either. In addition, many with mental illness, or addiction, or both, have significant chronic health conditions such as diabetes and heart disease. These conditions are largely responsible for a startling 25-year gap in life expectancy between those with serious behavioral health disorders and others in the population.

While many Marylanders suffer from mental illness, chronic health conditions, and substance abuse, the financing system that serves them is fractured:

- There is one path to access medical treatment and some behavioral health services in primary care, through Medicaid;
- There is a second path to access addiction services, through local jurisdictional grants; and
- There is a third path for specialized mental health care, through the Mental Hygiene Administration’s fee-for-service system.

These disparate paths rarely meet to provide coordinated care for patients. The combined costs of medical, substance abuse treatment, and mental health care for high-cost individuals can reach to the hundreds of thousands of dollars per patient per year. Yet our system rarely spends funding strategically to improve outcomes and lower costs.

Our approach must change.

The Department worked with stakeholders and engaged a consultant to examine options for the integration of behavioral health care. The Department has reviewed several specific options for a new financing system, but we are not prepared at this time to choose one to

propose for implementation. This report provides an overview of the stakeholder process and the work of the consultant, provides background and information on the various options, sets out key principles for reform, and explains our process for moving forward. Our plan is to bring specific proposals to the 2013 legislative session.

Consultant Review

Some steps towards integration have broad support in Maryland. Stakeholders are working with the Department, for example, to integrate regulatory oversight of substance abuse and mental health providers.

Improving the system of financing to support integrated care is a more complex challenge. To facilitate conversations among key stakeholders and provide a report with recommendations on financing, the Department engaged an experienced consultant. The consultant conducted five structured interviews with mental health and addictions treatment providers; consumers, families and advocates; core service agencies; 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 patient experience, lower costs, and improved outcomes.

Three listening sessions were held in early September 2011. One hundred and twenty-eight stakeholders attended meetings held in Cambridge, Catonsville, and Rockville. The purpose of the meetings was to receive participants' 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?

Two additional stakeholder meetings were held 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.

On December 5, 2011, a final draft of the report was posted on the DHMH integration website. DHMH received 36 sets of comments on the draft report from individuals, consumer organizations, behavioral health advocacy organizations, and healthcare organizations. The comments fell into the following categories:

- The desire for additional public discourse as DHMH moves to a decision;
- The need for additional data to support implementation of different options;
- Defining the role of local authorities in an integrated system;
- The need for training and technical assistance across the system;
- Regulations and the challenge of accreditation for some providers; and
- Factual corrections and edits.

The consultant's report, which is attached, provides a candid assessment of the strengths and weaknesses of Maryland's system of behavioral health care. Maryland invests considerable resources in behavioral health care, and thousands of citizens benefit from high quality, compassionate, and evidence-based care each year. At the same time, however, our current system largely pays on the basis of the volume of behavioral health services. Our current system does not pay on the basis of 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 additional observations about our current system:

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

The report provides details on a wide range of innovation underway around the country and available to Maryland. Looking to 2014, when the arrival 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, and 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 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 Managed Care Organizations 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.

Principles for Integrated Care

The Department is supportive of strengthening Maryland’s approach to behavioral health care. We are not prepared at this time to choose a specific financing strategy. After considering the substantial public input and comment over the past year, we intend to determine our next steps based on the following seven principles:

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.

The Department appreciates the constructive input of all stakeholders and the work of the expert consultant. A new system that meets all seven principles could be constructed under a range of options, including Option 1 or Option 2.

Organizational Alignment within the Department

To successfully develop a new system of integrated care in Maryland, the Department of Health and Mental Hygiene must align our organizational strengths to this challenge.

One agency within the Department should lead improvements in behavioral health outcomes by assessing public health data, establishing quality standards, establishing and funding innovative programs, supporting training, working with localities, and enhancing the state behavioral health workforce.

The Department intends to develop a proposal to consolidate the Mental Hygiene Administration and Alcohol and Drug Abuse Administration to create a single Behavioral Health Administration covering both mental health and substance abuse to serve in this role. The proposal will be reviewed by key stakeholders through public input and comment.

One agency within the Department should oversee the financing of medical, substance abuse, and mental health services. This organization should in effect serve as a purchasing authority, and be able to work with all responsible entities to set expectations for integration and align incentives. Regardless of what model of financing is selected –Option 1, Option 2, or another approach -- this organization should serve as the single point of

responsibility and accountability for making integration work for consumers and providers.

The Medicaid program is well-suited for this role. The Maryland Medicaid Program, led by the Deputy Secretary for Health Care Financing, has the expertise in the Department to (1) work with the Center for Medicare and Medicaid Services to obtain federal financing for innovative models of care through waivers and state plan amendments; (2) enroll providers and establish payment rates; (3) determine actuarially sound rates supported by audited financial reports; and (4) manage risk-based integrated delivery system contracts.

Working closely with the new behavioral health agency, Medicaid will be able to develop an effective financing structure to support high-quality integrated care.

Next Steps

To choose a specific financing model and develop a detailed implementation plan consistent with the seven principles, we must further define: (1) the potential mechanisms to align incentives across medical, mental health, and substance abuse treatment; (2) the models of care in Maryland in need of support; (3) the incentives we will deploy to support those models of care; (4) the measures by which we will evaluate the health care and financial outcomes of a new program; and (5) the capacity of various entities in Maryland to play critical roles in a new system.

The Department will establish a planning team led by the Deputy Secretary for Health Care Financing to review the financing and integration options. The team will cut across the Department and include representatives with expertise in behavioral health, public health, and clinical practice. The team will consider, among other topics, the implications of implementing a new approach, and the natural transitions in benefit design and delivery systems that will occur on January 1, 2014.

The team will solicit feedback, in its planning work, from a broad array of consumers, clinicians, provider organizations, advocates, local agencies, and managed care entities.

This team will develop a draft approach to integrate care based on the findings in the consultant's report and as refined through a planning process that involves outside stakeholders, by September 30, 2012. This approach will be presented for public comment and be incorporated into a specific proposal for the 2013 legislative session.

In addition, the Deputy Secretary for Health Care Financing will continue leading the development of a chronic care health home program, which could model some of the approaches to be supported by our new system.

The Department will also establish a second planning team to create an integrated Behavioral Health Administration with the functions outlined above. The planning team will present, for public comment, a draft plan by September 30, 2012 and develop a specific proposal for the 2013 legislative session.

**FUTURE OPTIONS
FOR
INTEGRATED BEHAVIORAL HEALTHCARE**

Presented to:

THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FUTURE OPTIONS FOR INTEGRATED BEHAVIORAL HEALTHCARE**

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INTRODUCTION

Maryland is evaluating its current system for managing and delivering publicly-financed behavioral health services as State policymakers plan for 2014 and the implementation of the Affordable Care Act (ACA). This evaluation covers services funded and purchased by Medicaid, the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration within the Maryland Department of Health and Mental Hygiene. Maryland's goal is to provide comprehensive, high quality and cost effective health services for persons with primary and secondary behavioral health conditions. Making this goal real and transforming disparate and disconnected health sectors into a seamless and transparent patient experience involves at least two categories of transformational change. First, *professional practices* must adapt to clinical guidelines, standards, and processes that promote wellness, and identify, treat, and follow up on general medical and behavioral health conditions. Second, the *policy, financing, and organizational contexts* that support general medical and behavioral health care must align and support integrated care.

Patients of all types of health care today routinely describe their experience as fractured, intermittent, and unfortunately too often including omissions and errors. This experience applies equally within a single episode for a single condition, as well as when multiple conditions require simultaneous treatments. It especially applies to patients with coexisting chronic general medical and behavioral health conditions. Arguments for integrating care are more than compelling. With clinical experts advising that "Dual diagnosis [mental and addictive disorders] is an expectation, not an exception"¹, discontinuous treatment makes no sense for persons with co-occurring mental health and substance use disorders (MH/SUD). For Medicaid, the opportunity to improve treatment for beneficiaries with co-morbid general medical and behavioral health conditions can only occur within integrated clinical practice. The top five percent of highest cost adult beneficiaries account for more than 50% spending; almost fifty percent of those with disabilities also have psychiatric illness; and the presence of psychiatric illnesses increases spending and hospitalization rates by as much as seventy-five percent.² Annual Medicaid per capita health care costs are three to four times higher for disabled beneficiaries who have co-occurring behavioral health conditions.³

BACKGROUND

In order to review its current system and consider options for the future, DHMH engaged a consulting team to advise them on possible approaches to integrating benefits management and care. The team has evaluated public financing initiatives in other States, identified innovative practices, reviewed development in healthcare relevant to improved patient care and integrated systems, held two rounds of five stakeholder listening sessions, reviewed preliminary data from Maryland's public systems and critiqued the State's benefits management structure in relationship to its ability to facilitate integration at the payer, provider and patient level.

MARYLAND'S CURRENT SYSTEM

Like most States, Maryland has a variety of funding streams, management structures and payment arrangements for its publicly supported Mental Health and Substance Use Disorder (MH/SUD) treatment system. Although all three public purchasers (Alcohol and Drug Abuse Administration, the Mental Hygiene Administration and the

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

² RG Kronick, et al., *The Faces of Medicaid III: Refining the Portrait of people with Multiple Chronic Conditions*, Center for Health Care Strategies, October, 2009.

³ Boyd, C., *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services*, Center for Health Care Strategies, December 2010.

Medical Assistance Program) are located within the Department of Health and Mental Hygiene there is a great deal of difference among their methods for funding and purchasing behavioral health services.

Medicaid's 1115 waiver authorizes the HealthChoice and Primary Adult Care programs through which eighty percent of Medicaid beneficiaries are enrolled in risk-based managed care for medical coverage. Persons needing "specialty mental health care" have received their mental health benefit through managed fee-for-service by an Administrative Service Organization under contract to the Mental Hygiene Administration since 1997. Under the HealthChoice 1115 waiver, MCOs are responsible for the provision of *primary* mental health services which are defined as "the clinical evaluation and assessment of services needed by an individual, and the provision of services or referral for additional services as deemed medically appropriate by a primary care provider". MHA is responsible for funding medically needed mental health services to all eligible recipients, except those mental health services which the primary care provider may render at its discretion.⁴ The ASO operates a utilization management system; pays claims; provides data collection and management information services; offers public information, consultation, training and evaluation services; and manages special projects.

Medicaid covers a limited SUD benefit for recipients who are enrolled in either HealthChoice or the Primary Adult Care program. The PAC SUD benefit includes comprehensive assessment, outpatient services, intensive outpatient and opioid maintenance treatment, while HealthChoice additionally covers partial hospitalization, youth residential and inpatient treatment, and medically managed inpatient detoxification. Seven fully capitated MCOs manage the HealthChoice benefit and five of them also manage the Primary Adult Care benefit.⁵ Only two of the seven plans (United Healthcare and Coventry) participate in Maryland's commercial market⁶. Any MCO that meets DHMH's regulatory standards is entitled to participate in either managed program, although the Department is currently evaluating whether to selectively contract with MCOs for HealthChoice and PAC⁷.

Utilization data on the Medicaid behavioral health benefit showed that, in 2010, eleven percent of Medicaid enrollees were given a MH or MH and SUD diagnoses and used behavioral health services in the Specialty Mental Health System.⁸ That same year, twenty-eight percent of Medicaid enrollees were given a MH and/or SUD diagnosis and used at least one Medicaid covered service associated with those diagnoses (this number would include those served through the Specialty Mental Health System).⁹ The recent *Joint Chairmen's Report* included data showing that three percent of Medicaid enrollees were given a SUD diagnosis and received SUD treatment through Medicaid in FY2010; for the Primary Adult Care program the SUD penetration rate was fifteen percent that year.¹⁰ While these data provide a basic snapshot of access to the Medicaid behavioral health benefit, further analysis on utilization of behavioral health in primary care settings, expenditure patterns for primary and specialty behavioral health services by Medicaid eligibility group, and expenditures by level of care would allow Maryland to more precisely evaluate its Medicaid coverage. Analysis of similar data for services MHA and ADAA purchase for persons who are uninsured would complete the picture of Maryland's publicly-financed behavioral health system.

Maryland utilizes significantly different methods for financing publicly supported mental health and substance use disorder treatment. Although both the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) delegate responsibilities to local authorities, their role in funding is substantially different. ADAA provides funding for services through grants and contracts to private and non-profit providers and local

⁴ DHMH RFP for the Administrative Service Organization, August 2008.

⁵ AmeriGroup, Priority Partners, Maryland Physicians Care, United Healthcare, MedStar, Family Choice, Jai Medical Systems and Coventry; MedStar Family Choice and Coventry do not participate in PAC.

⁶ DHMH White Paper, *Maryland HealthChoice Program: Should Maryland Move to a Selective Contracting Strategy?*, July, 2010

⁷ Ibid.

⁸ Mental Hygiene Administration, *Public Mental Health System Data Report*, September 2011.

⁹ University of Maryland-Baltimore County/The Hilltop Institute, *Frequency of Medicaid Service Utilization*, August 2011.

¹⁰ DHMH, *Joint Chairmen's Report* (p. 81), November 2011.

health departments. Most dollars are allocated to local health departments that either provide services directly or contract with community-based provider organizations.

For MHA, Core Service Agencies function as the local mental health authorities responsible for planning, managing and monitoring Maryland’s PMHS. They provide information and referral, handle complaints, and monitor ‘non-FFS’ contracts. Both the ASO and CSAs authorize mental health services, coordinate care and manage high cost users and diversion to lower levels of care.¹¹ CSAs are engaged in extensive collaboration with other systems, develop innovative services, and monitor providers for quality and compliance; the MHA makes grants to CSAs for state-only special purpose funding.

For youth, Maryland has a system of specialized local authorities for children and families, the Local Management Boards (LMB). LMBs receive Children’s Cabinet Interagency Funds (CCIF) to ensure a continuum of prevention and early intervention services by developing collaborative partnerships with public agencies and community resources.¹² They assess community needs; manage state, federal and community grant dollars; develop and manage service contracts; monitor LMB-funded services; and measure performance to ensure program outcomes are met.¹³

Maryland has also received a Centers for Medicaid and Medicare Services (CMS) *Children’s Health Insurance Program Reauthorization Act* (CHIPRA) Quality Demonstration Grant to implement a Care Management Entity (CME) model for children who have serious behavioral health challenges and are Medicaid beneficiaries. Partially to support the implementation of Maryland’s 1915(c) Psychiatric Residential Treatment Facility Medicaid Waiver, the state has entered into contracts with two not-for-profit companies to serve as three Regional Care Management Entities (CME). CMEs currently serve youth in the PRTF 1915c Demonstration Waiver, two System of Care grants, State-funded Department of Juvenile Services (DJS) out-of-home placement diversion, and State-funded Department of Human Resources (DHR) group home diversion. There are three targeted populations who receive care coordination from the CMEs with funding either from Medicaid administrative claiming for waiver enrollees, from federal System of Care funds for grant participants or from State-only funds for all other enrollees. Medicaid eligible youth receive their medical and behavioral health services through the Specialty Mental Health System’s ASO, Medicaid’s MCOs, ADAA’s grant allocations or specialty services funded by Core Service Agencies. Residential Treatment Centers (RTC) are financed by the Specialty Mental Health System and DJS and DHR may pay for non-RTC level of care residential needs. At part of its CHIPRA grant, Maryland plans to establish a case rate incorporating all funds supporting CME youth; a single payer system and a ‘one youth, one care manager and one plan’ model.¹⁴

Table 1. Maryland’s Purchasing and Care Coordination Entities

	Mental Health	Substance Use Disorder
Purchasing/Funding	Medicaid, MHA, Children’s Cabinet Interagency Fund	Medicaid, ADAA, Children’s Cabinet Interagency Fund
Local Authorities	Core Service Agencies Local Management Boards	Local Health Departments Local Management Boards
Care Management/Care Coordination	Managed Care Organizations Administrative Service Organization Care Management Entities	Managed Care Organizations Administrative Service Organization Care Management Entities

¹¹ Maryland Association of Core Service Agencies, *Integrated Care for Individuals with Behavioral Health Disorders*, August 2011.

¹² *FY2010 Annual Report*, Maryland Association of Local Management Boards, October 2010.

¹³ Ibid.

¹⁴ Grimm, G. *Financing Care Management in Maryland*, CHIPRA Quality Demonstration Grant TA Webinar Series, June 2010.

For MH and SUDs, community-based multi-purpose, hospital or specialty (e.g. residential, psychosocial rehabilitation) organizations provide the majority of behavioral health treatment for the Medicaid and the uninsured population.

OPPORTUNITIES UNDER HEALTH REFORM

Expanded Coverage

Maryland Medicaid and the Maryland Children’s Health Program (MCHP) provide health care services to just under one million low-income individuals. Beginning in January 2014, the Medicaid expansion that is included in the Affordable Care Act (ACA) is expected to add approximately 175,000 individuals to Medicaid and these individuals will receive coverage from the Medicaid managed care organizations.¹⁵ The newly created Maryland Health Insurance Exchange will provide coverage for an estimated 187,000 adults in the subsidized individual market for persons between 133 and 400 percent of the federal poverty level.¹⁶ For persons between 133 and 300 percent of the FPL, parents and children would be in different programs: parents’ coverage would be subsidized through the Exchange and their children would be Medicaid or MCHP. States that have already expanded Medicaid to low-income childless adults have identified this population as having high need for behavioral health treatment, with many of them currently relying on the public system for access to treatment. In 2014 their health insurance coverage will shift from grant-funded services for persons who are uninsured to either the Medicaid program or Health Plans who are subsidized through the Exchange.

Many states are attempting to create a high degree of overlap in Qualified Health Plans under the Exchange and those who contract with Medicaid in order to maximize health plan enrollment and continuous access to providers. Even if eligibility determination and enrollment policies and practices minimize administrative “churn”, there will most likely be relatively large numbers of individuals who move back and forth across Medicaid and the Exchange due to changes in economic conditions. A recent Commonwealth Fund report, for example, found that twenty-five percent of individuals with 2005 incomes below 133% FPL would not have qualified for Medicaid based on annual income in 2006. Similarly, for those between 134% and 199% FPL in 2005, in 2006 17% dropped below 133% FPL and thirty percent moved to a category where they would have qualified for Medicaid.¹⁷

Both the Medicaid expansion population and those subsidized through the Exchange will have access to ACA-defined “Essential Health Benefits” that include behavioral health services and whose scope is equal to the scope of benefits provided under a typical employer plan. While the richness of the EHB is unknown until the Secretary of Health and Human Services defines them, 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. The ACA also added behavioral health services and prescription drug coverage to the list of services that must be included in Benchmark Plans and Benchmark Equivalent Plans that are offered by Medicaid to expansion populations who do not have access to the “traditional Medicaid benefit”.

The Impact of Parity

One historical argument for separate management of behavioral health benefits was based on the fact that there was typically not ‘parity’ between health and behavioral health around financing, benefit design, and utilization management by insurance companies. With the enactment of the federal parity act and its effective date of July 1, 2010, all health plan that offer a behavioral health benefit, must offer it ‘on par’ with the medical/surgical benefit; MCOs that manage Medicaid benefits are included in this group. Plans cannot apply any financial requirements or treatment limitations to behavioral health that are more restrictive than those used for medical/surgical benefits.

¹⁵ DHMH, *Maryland HealthChoice Program: Should Maryland Move to a Selective Contracting Strategy?*, July 2011.

¹⁶ *Ibid.*

¹⁷ *Realizing Health Reform’s Potential*, The Commonwealth Fund, May 2011.

Adherence to parity requirements will also create access to health insurance coverage for individuals who currently rely on publicly-subsidized treatment.

THE CHANGING HEALTHCARE LANDSCAPE

Both through the Affordable Care Act and developments occurring in medical and behavioral health systems across the country, new delivery systems are emerging for enhancing treatment in primary care, for improving management of chronic conditions and for managing care for special populations. Examples are:

- Patient-Centered Medical Homes
- Medicaid State Plan Amendments: Health Homes
- Specialty Integrated Delivery Systems
- Accountable Care Organizations

Patient Centered Medical Homes

Patient Centered Medical Homes (PCMH) were first proposed for children with special needs and the concept has been resurrected as a best practice for both children and adults and as a possible platform for chronic disease management. At its basic level, a medical home rejuvenates the definition of primary care as the site of first-contact, with responsibility for patients over time; providing comprehensive care that meets or arranges for most of a patient's healthcare needs; and coordinating care across a patient's conditions, care providers and settings.¹⁸ Others have added criteria that include the patient having a regular doctor or source of care; having no difficulty contacting them by phone; having no difficulty getting care or medical advice on evenings and weekends; and experiencing office visits that were well organized and running on time.¹⁹

There is also growing support for using the medical home as the location for managing chronic conditions, although some experts question whether most primary care practices can be re-designed to support patients with chronic disease and adhere to the six components of the Group Health Cooperative's "Chronic Care Model". This model requires that healthcare organizations implement delivery system redesign, systematic decision support, linkage to community resources, self-management support and clinical information systems²⁰. Early work by Wagner and others identified three core components of chronic care management as targeted goal setting and planning, developing a continuum of self-management training, and sustained direct contact with patients at regular intervals, all organized by clinical care managers who function as health educators and navigators.^{21, 22} This more modest set of clinical activities may be realistic for medical homes who, with patient partnerships, would manage chronic conditions.

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association issued a joint statement on the core principles of a patient-centered medical home. They are:

- Personal physician – each patient has an ongoing relationship with a primary care provider.
- Physician-directed medical practice – the personal physician leads a team at the practice level which collectively takes responsibility for the patient's care.
- Whole person orientation – the personal physician is responsible for the patient's healthcare needs across the lifespan or arranging such care.

¹⁸ B. Starfield and L. Shi, *The Medical Home, Access to Care, and Insurance: A Review of Evidence*, Pediatrics, 113, no 5 Supp. (2004).

¹⁹ *Closing the Divide: How Medical Homes Promote Equity in Health Care*, The Commonwealth Fund, June 2007.

²⁰ E. Wagner, et al., *Organizing Care for Patients with Chronic Conditions*, Milbank Quarterly 74, no. 4 (1996).

²¹ M. Von Korff, et al., *Collaborative Management of Chronic Illness*, Annals of Internal Medicine, December 1997.

²² E. Wagner, *More Than a Case Manager*, Annals of Internal Medicine, October 1998.

- Care is coordinated – care is integrated across all elements of health care, including subspecialty, hospitals, nursing homes and the patient’s community.
- Quality and safety – quality and safety are hallmarks of the medical home.
- Enhanced access to care – there are expanded hours and web-based communication with patients.
- Payment – payment reflects the added value provided to patients through the PCMH model.

Newer PCMH models embed community health workers in clinics and practices to assist patients with connections to specialty medical care, behavioral health treatment, and supportive services like housing and transportation.²³ In some cases a community health worker is incentivized by being tied to specific patient outcomes.²⁴ In many systems, a single health worker has replaced seven to ten caseworkers that were associated with dozens of funding sources, with no coordination. Evaluations of PCMH initiatives indicate that quality of care, patient experiences, care coordination and access are better than those for primary care.²⁵ An evaluation of Medicaid PCMH efforts in North Carolina and four other states (AR, IN, OK, PA) indicated that they may perform “equal to or better than capitated MCOs on measures of access, cost and quality”.²⁶ Strengthening primary care produces reductions in emergency department visit and inpatient hospitalization in a relatively short period of time.²⁷

PCMH development is occurring across the country in both the public and private sectors involving Medicaid and commercial health plans; some initiatives include all payers, like those in Vermont, Michigan and Pennsylvania in addition to Maryland’s own pilot. Medicaid has taken a strong lead in states like Colorado with its *Children’s Health Care Access Program* (CCHAP) and North Carolina’s *Community Care of North Carolina* (CCNC). With foundation support, Colorado’s CCHAP was tasked with increasing physician participation in Medicaid and the Children’s Health Program, with rates skyrocketing from 20% to 93%. Medicaid increased some rates to those paid by Medicare and enhanced rates for preventive visits if practices met medical home standards developed by the State. Practices conduct a self-assessment and a PCMH Navigator validates this assessment through an on-site visit. Medicaid funds a non-profit family advocacy organization to hire the navigators who certify practices annually.²⁸

Community Care of North Carolina requires providers to form networks to link primary care, safety net and specialty providers in collaboration with hospitals and local departments of health and social services. Fourteen regionally based networks of 3,500 primary care providers function as medical homes for one millions beneficiaries of Medicaid and the Children’s Health Insurance Program. Each network has a common infrastructure of a Medical Director, Clinical Coordinator, Care Managers and Pharmacist and provides shared services to the primary care practices as well as quality medical management and educational outreach to network providers. Each network receives a PMPM payment for medical management and practices receive a PMPM payment for meeting state requirements. Evaluations have shown the CCNC saved over \$200 million in overall costs and improved outcomes for selected health conditions.²⁹

²³ *The New Wave of Innovation: How the Health Care System is Reforming*, The Commonwealth Fund, November, 2011.

²⁴ Ibid.

²⁵ Grumbach K., et al., *The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access, and Costs from Recent Prospective Evaluation Studies*, August 2009, Available at www.pcpcc.net

²⁶ Verdier, et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*, Center for Health Care Strategies, 2009 cited in Devers, K. et al., *Innovative Medicaid Initiatives to Improve Service Delivery and Quality of Care*, Kaiser Commission on Medicaid and the Uninsured, September 2011.

²⁷ Ibid.

²⁸ Takach, M. et al., *Strengthening Primary and Chronic Care: State Innovations to Transform and Link Small Practices*, National Academy for State Health Policy, December, 2010.

²⁹ Ibid.

The Commonwealth Fund's *Safety Net Medical Home Initiative* is assisting more than sixty five community health centers in five states (Colorado, Idaho, Massachusetts, Oregon and Pennsylvania) transform their practices into patient-centered medical homes. Through five Regional Coordination Centers³⁰, Qualis Health of Seattle and the MacColl Institute for Healthcare Innovation provide support to the States and the centers in meeting patient-centered medical home standards.

Federally Qualified Health Centers (FQHC) which have a growing presence in the safety net, including Maryland's, are preparing for expanded coverage through Medicaid and the Exchanges in a number of ways, one of which is transforming their practices into patient-centered medical homes. As of 2011, six percent have attained NCQA recognition as a PCMH, twelve percent have a pending application, and forty percent will seek recognition in the next 18 months.³¹ CMS' Medicare FQHC Advanced Primary Care Practice demonstration project will require that participating centers meet Level 3 NCQA recognition by the end of the project and will involve up to five hundred FQHCs. Participating centers will receive a monthly case rate for enrollees and must have at least two hundred Medicare patients. HRSA's Bureau of Primary Care provides financial assistance to FQHCs to become NCQA-recognized by covering application fees. Medicaid provides electronic health record incentive payments to clinicians at FQHCs that have a high volume of Medicaid patients or needy individuals.

Maryland recently launched its own multi-payer Patient Centered Medical Home Program. The program is designed to improve patient health and elevate the role of the primary care provider to "provide a first, coordinated, ongoing and comprehensive source of care to patients".³² This is a three-year pilot program overseen by the Maryland Health Care Commission with a goal of enrolling over 200,000 patients in the medical home program through fifty practices and two hundred providers. All major carriers (including Medicaid) will make enhanced payments to pilot practices through a per member per month rate for care coordination and practice transformation, with opportunities for shared savings in the second year of the demonstration. Pilot sites must obtain NCQA Level 1 Recognition by June, 2012 and Level 2 Recognition by June, 2013. Services to be provided through the pilot include: evidence-based medicine; expanded access and communication; wellness and prevention; care coordination and integration; and culturally and linguistically sensitive care.³³

Medicaid State Plan Amendments: Health Homes

Under Section 2703 of the Affordable Care Act, State Medicaid Agencies are authorized to develop State Plan Amendments (SPA) for *Health Homes* that integrate and coordination primary, acute, behavioral health and long-term services and supports for persons across the lifespan with chronic illness.³⁴ Consistent with CMS guidance, Health Homes use a 'whole-person' philosophy to integrate primary care and behavioral health services by providing comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient settings; individual and family support; referral to community and social support services; and the use of health information technology to link services, as feasible and appropriate³⁵. Health home services are reimbursed at a 90% Federal Medical Assistance Percentage (FMAP) rate for the first eight quarters that a SPA is in effect. These services may be offered to eligible individuals with chronic conditions who select a health home provider. Because the statute waives comparability, health home enrollees may receive services in different amount, duration and scope than other Medicaid beneficiaries. However, since health homes are authorized as a

³⁰ Massachusetts League for Community Health Centers and the State Executive Office of Health and Human Services, Oregon Primary Care Association and CareOregon, Colorado Community Health Network, Idaho Primary Care Association, Pittsburgh Regional Health Institute.

³¹ Ku, L., et al., *Transforming Community Health Centers into Patient-Centered Medical Homes: The Role of Payment Reform*, The Commonwealth Fund, September 2011.

³² SB 855/HB 929

³³ Maryland Health Care Commission at www.mhcc.maryland.gov

³⁴Centers for Medicare and Medicaid Services, letter to State Medicaid Director and State Health Official, SMDL#10-024, ACA#12, November 16, 2010.

³⁵ Ibid.

SPA, they must be available on a statewide basis. Chronic conditions described in the ACA include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and obesity. Individuals must have at least two chronic conditions, one chronic condition and be at risk for a second, or one serious and persistent mental health condition. The population must include all categorically needy individuals as well as Medicaid/Medicare dual eligibles. Beneficiaries may receive health home services from designated providers, a team of health care professionals linked to a designated provider, or a health team; all are defined in the ACA. States have flexibility in designing payment methodologies that recognize the severity of each individual's chronic condition and support the identified functions of the health home.

Several States are developing health home SPAs with a behavioral health focus. Having worked on behavioral health integration efforts for the last five years, **Missouri** has recently submitted a State Plan Amendment for behavioral health homes (BHH) that will use the State's network of twenty five Community Mental Health Centers (CMHC) in this capacity. Medicaid beneficiaries will be eligible to enroll in a BHH if they have a serious and persistent mental health condition, a mental health condition and one other chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability or obesity) or a substance use disorder and one of the other chronic conditions listed above. Health homes will be physician-led with teams minimally comprised of a Nurse Care Manager, a health coach who is either a Registered Nurse or specially trained as a health coach and supervised by a Registered Nurse and other clinic support staff. Optional team members include a case manager, nutritionist/dietician, pharmacist, peer recovery specialist or other representatives as appropriate to meet clients' needs. Implementation will be supported through a statewide Learning Collaborative, monthly practice team calls to reinforce the learning sessions, and practice coaching. CMHCs submitted applications for health home designation in which they demonstrated their ability to meet the initial provider standards, including enhanced access to the health team, utilization of an interoperable patient registry and use of Medicaid's comprehensive electronic health record. Within eighteen months CMHCs must attain NCQA Level 1 recognition or meet comparable State standards. In addition to fee-for-service reimbursement for Medicaid covered services, health homes will receive a first-quarter, start-up infrastructure payment, a clinical care management case rate payment (per member per month), and a performance incentive in the form of shared savings. No individual practice will receive a performance incentive until the statewide health home program realizes a reduction in total fee-for-service PMPM costs.

As a companion to their behavioral health home program, **Missouri** has also submitted a SPA for a network of primary care health homes to be operated by Federally Qualified Health Centers, Rural Health Centers and primary care clinics operated by public safety net hospitals. Persons with two chronic conditions or one chronic condition and tobacco use are targeted. Practice sites will be physician-led with the health team comprised of a primary care physician, nurse practitioner, licensed nurse or medical assistant, behavioral health consultant, a nurse care management and the practice administrator or office management. Health home service definitions, provider standards and health information technology requirements are identical to those for the behavioral health health homes.

New York plans to phase in Medicaid health homes beginning in January, 2012 by certifying health homes that build on current provider partnerships. The State has identified almost one million enrollees who are high cost/high need individuals with two or more chronic conditions and/or a serious mental illness; the first initiative will focus on beneficiaries with behavioral health and/or chronic medical conditions. Approved health homes will directly provide or contract for health home services to the identified target population. Eligible individuals will be identified by the State and assigned to a provider based on existing relationships, geography, or qualifying condition. Beneficiaries will be auto-enrolled in a health home and then be given the option to choose a different provider or opt out of enrollment in a health home. NY's health homes will use multidisciplinary teams of medical mental health, chemical dependency treatment providers, social workers, nurses and other practitioners led by a dedicated care manager who, with the patient, will create a single care management record. NY is working toward the development of a single portal to be used by health homes for submission of functional assessment and quality measure reporting. Health home providers will be paid a monthly case rate that is adjusted based on region, enrollment volume, and case mix. The care management fee will be paid in two increments based on whether the patient is in the case finding group or the active care management group.

Specialty Integrated Delivery Systems

Parallel to both Medical Home pilots and use of the Medicaid State Plan Option for Health Homes, States are also developing *Integrated Delivery Systems* for Dual Medicaid/Medicare Eligibles that build on a variety of delivery platforms, including Managed Care Plans, Accountable Care Organizations, and Health Homes. These systems contain many of the features of those platforms and involve assertive care coordination, single accountability for a plan of care, as well as innovative rate-setting and payment models. (Note that Health Homes under Section 2703 must also serve Dual Eligibles but can serve a broader Medicaid population as well.) North Carolina, for example, is using its CCNC PCMH network as the delivery platform for a Medicare waiver that targets high cost dual eligibles; it will eventually add Medicare-only beneficiaries to this demonstration.

Similarly, a handful of States or local communities have created specialized delivery and care coordination systems for youth with serious emotional disturbances.³⁶ Initiated in 1996, *Wraparound Milwaukee* is the longest standing such system and is described by the County as “a unique type of managed care program operated by the County that is designed to provide comprehensive, individualized and cost effective care to children with complex mental health and emotional needs”.³⁷ Funds from four agencies are pooled to divert children from residential or correctional placement or psychiatric hospitalization. Nine community agencies employ the care coordinators who facilitate access to treatment using an individualized ‘wraparound’ approach.

On a statewide level, in 2000 **New Jersey** established its *Children’s System of Care Initiative* to serve the total population of youth with emotional and behavioral health disorders who depend on public support for their care. The population includes both Medicaid and non-Medicaid-eligible youth who have either acute or intensive service needs. Funds from all State agencies that purchase behavioral health services are pooled in a contract with a statewide Administrative Services Organization that authorizes, coordinates and tracks care for all children. Care Management Organizations (CMO) were created at the local level to provide individualized service planning and care coordination for children with intensive and complex needs. CMOs were required to create partnerships with Family Support Organizations (FSO) to make family and peer support, community resources and advocacy available.

Maryland’s CME initiative is an example of a specialty delivery system for youth with serious behavioral challenges that coordinates care and funding across behavioral health, child welfare, juvenile services and education. CMEs use the Wraparound model to promote a coordinate care planning process built on Child and Family Team (CFT) meetings. Maryland intends to improve the utilization management functions for youth enrolled in the CME; ensure the appropriate use of medication with children and youth; refine the systems and practice models of peer-to-peer support; and identify a crisis response system model for children and youth.³⁸

Accountable Care Organizations

An Accountable Care Organization (ACO) is a service delivery and financing model designed to better coordinate preventive, primary and tertiary patient care. Included as a Medicare demonstration under the Affordable Care Act (ACA), the ACO model is viewed largely as the future of health care financing in both public and private insurance markets for its ability to incent providers to reduce unnecessary and duplicative care and share in the savings derived from lowering patient care expenses. Many commercial insurance carriers are already working to include shared-savings models into their contracting with hospitals and primary care practices. While there is market flexibility in how ACOs are formed, three core characteristics have been defined: 1) provider-led organizations with a strong base of primary care that is collectively accountable for quality and total per capita

³⁶ Only four States have statewide coverage: Maryland, Massachusetts, Georgia and New Jersey. Massachusetts’ CME are network providers for Medicaid MCOs.

³⁷ County.milwaukee.gov/WraparoundMilwaukee

³⁸ Innovations Institute at <http://medschool.umaryland.edu/innovations/>

costs for enrolled patients; 2) payments linked to quality improvements that also reduce cost; and 3) reliable and progressively more sophisticated performance measurement to provide confidence that savings are achieved through improvements in care.³⁹

ACOs must be able to provide or manage a continuum of care as a real or virtually integrated delivery system; are of sufficient size to support comprehensive performance measurement and improvement; and are capable of prospectively planning budgets and resource needs and sharing revenue and risk among the ACO participants.⁴⁰ An ACO will typically be large health care systems or a network of health providers working across patient care settings (including behavioral health) that come together to create an ACO for a defined group of beneficiaries. The ACO must deliver highly coordinated patient-centered, evidence-based care and promote patient engagement. The ACO must also develop the ability to report on patient quality indicators and cost measures that can be used to determine the distribution of any savings achieved through the ACO model. Provider reimbursement is tied to quality metrics and reductions in total cost of care for enrolled patients.

The National Committee on Quality Assurance (NCQA) has developed draft standards for ACOs which focus on the following criteria:

- Program Structure Operations – the ACO has an appropriate organizational and leadership structure; can effectively manage resources, including arranging for pertinent health care services; and can determine payment and contracting arrangements with its providers.
- Access and Accountability - the ACO has sufficient numbers and types of providers for primary and specialty care.
- Primary Care – the ACO offers patient centered primary care.
- Care Management – the ACO collects and uses clinical and administrative data to identify patient and population health needs.
- Care Coordination and Transitions – The ACO ensure timely exchange of information between primary care, specialty care and hospitals for care coordination and patient transitions.
- Patient Rights and Responsibilities – the ACO has a commitment to patient rights and privacy.
- Performance Reporting – the ACO measures and reports on clinical quality of care and cost.

While primary care and hospital level services will be the primary focus of the ACO, ACOs will also need to ensure that there is adequate availability of specialty providers within its network. ACO will either need to develop these specialty services in-house, or contract for these services from existing providers. For MH and SUD providers there will undoubtedly be opportunities to participate in ACO as long as the provider has the capacity to not only provide services in an efficient and effective manner, but can also meet the other aspects of the ACO criteria listed above. This will include the ability to collect quality care measures and track cost data⁴¹.

As mentioned earlier, ACO development under the ACA has focused solely on Medicare beneficiaries, with little discussion nationally on the using ACOs for Medicaid beneficiaries. However, given the purchasing power of state Medicaid programs, there is great potential to use the shared savings model of an ACO in a demonstration focused on Medicaid enrollees. A June 2011 policy brief from the Center for Health Care Strategies explores a number of key issues states and CMS would need to consider if they were to pursue a safety-net ACO for Medicaid beneficiaries.⁴² These include such factors as ways to mitigate financial risks to safety net hospitals and training, technical assistance and financial assistance to providers to ensure their information systems are capable of collecting and sharing patient level data. ACOs hold promise for the specialty behavioral health system since they

³⁹ McClellan, M. et al., *A National Strategy to Put Accountable Care into Practice*, Health Affairs, May, 2010.

⁴⁰ Fisher, E. *Growing Demand for Accountability Webinar*, National Quality Forum, October, 2009.

⁴¹ Alexander, L., *Partnering with Health Homes and Accountable Care Organizations*, National Council for Behavioral Healthcare, January, 2011.

⁴² McGinnis, T. and Highsmith, N., *Accountable Care Organizations: Creating a Workable Approach for Medicaid*, Center for Health Care Strategies, June, 2011.

operationalize the public system’s principle of a client-centered system of care through an integrated delivery system that surrounds an enrolled patient population.

The National Academy for State Health Policy has identified seven states who were leaders in the development of PCMHs and who are now pushing forward on ACOs.⁴³ After its successful venture into PCMHs, Colorado has developed regional “community care organizations” (RCCO) that follow an ACO model for Medicaid beneficiaries. The RCCOs provide medical management for medically and behaviorally complex clients, care coordination across behavioral health, long-term care and other social services such as food, transportation and nutrition, and offer providers support with clinical performance and practice improvement and redesign. For each enrollee, Medicaid pays the RCCO a PMPM that is shared with providers; there is also gain sharing with the RCCOs and providers.

Through its latest state-based healthcare reform, Oregon will move one million Medicaid beneficiaries and government employees into “coordinated care organizations” that are similar to ACOs. Integrated delivery systems with global budgets holding providers accountable for outcomes and cost, CCOs will integrate physical, behavioral health and dental services as a single delivery system under one organization. With Governor Kitzhaber presenting a CCO implementation plan to the legislature in February, 2012, many of Medicaid’s current managed care organizations (Prepaid Health Plans) are positioning themselves to become CCOs by creating one-stop clinics where patients can get both their medical and behavioral care.

BENEFITS MANAGEMENT

Medicaid Managed Care

State Medicaid Agencies use either managed care or fee-for-service arrangements in purchasing services for beneficiaries. Managed care arrangements are specified in the Center for Medicaid and Medicare Services (CMS) rules that implemented the Balanced Budget Act of 1997 and include the following⁴⁴:

Risk-based Managed Care Organizations or Health Plans

States contract with MCOs to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitated basis. Medicaid MCOs may be commercial HMOs that also serve people with employer-sponsored insurance, or they may be Medicaid-only plans with no commercially insured members. Medicaid MCOs may be licensed by the state, or they may operate under a contract with a Medicaid agency regardless of licensure. Specialty services may be carved out (see Prepaid Health Plans below) and this is the approach Maryland has taken for mental health, with MCOs for HealthChoice and PAC managing health and addictions treatment while MHA’s ASO manages the mental health benefit for all Medicaid beneficiaries.

Primary Care Case Management Programs

PCCM is also considered a form of Medicaid managed care that builds on the fee-for-service system, adding a monthly case rate payment for all PCCM enrollees. Medicaid often contracts with an Administrative Service Organization (ASO) or Third Party Administrator (TPA) to provide administrative support and infrastructure for the PCCM program. A number of states have recently created “enhanced PCCM” with disease management services, coordination/integration of physical and mental health services, case management for high cost enrollees, etc. (Note: PCCM may not be relevant to Maryland’s considerations for behavioral health integration unless it is embedded within Patient-Centered Medical Homes as described later in this document.). Maryland does not use this model.

⁴³ Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont and Washington in Purrington, K. et al., *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations*, February, 2011.

⁴⁴ *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, The Kaiser Commission on Medicaid and the Uninsured, September 13, 2011.

Prepaid Health Plans

States contract with PHPs on a risk basis to provide non-comprehensive benefits to enrolled Medicaid beneficiaries. Common types of non-comprehensive PHPs provide only behavioral health services which, in many instances, are carved out of the benefit package provided by the MCOs. All of the existing risk-based mental health or behavioral health carveouts would be considered PHPs (e.g. Arizona, Iowa, Pennsylvania). Maryland's ASO would not be considered a PHP since it does not manage insurance risk for Medicaid beneficiaries.

In either of the two risk arrangements (MCOs/HPs and PHPs), robust performance standards are critically important so that the purchaser's quality and outcome goals are met. Whether the behavioral health benefit is managed within a Health Plan or by a specialty Prepaid Health Plan, identification of key clinical processes (e.g. Screening, Brief Intervention, and Referral to Treatment [SBIRT] conducted by primary care), indicators of access to care (e.g. penetration rates) and measures of collaborative treatment (e.g. communication between somatic and behavioral health providers) must be specified so that expectations around treatment and service integration are clear. Either of the two risk arrangements can contract with provider-sponsored organizations and share partial risk with providers or networks. Several of Arizona's Regional Behavioral Health Authorities contract with provider-sponsored networks, for example.

Fee-for-Service arrangements can be unmanaged by Medicaid; managed through regulations, contract conditions or utilization limits; or managed by an intermediary that applies utilization management systems to control service access, spending, etc. Fewer and fewer States are using unmanaged approaches, given fiscal constraints as well as their interest in increasing access to care at predictable, or lower, cost. In these arrangements, the State retains all risk for utilization levels and spending. MHA's ASO contract with ValueOptions would fall under this model.

A recent Kaiser Commission report identified an array of trends in relationship to State Medicaid Agencies and managed care:

- Two-thirds of Medicaid beneficiaries are enrolled in comprehensive managed care programs;
- States are increasingly beginning to move beneficiaries with complex needs into managed care;
- More than half the States have some form of pay for performance feature in their payment methods;
- The use of minimum Medical Loss Ratio requirements is increasing;
- Dental care and behavioral health benefits are the services most often carved out of MCO contracts;
- Some states with carve outs are beginning to carve benefits back into MCO contracts;
- Most non-comprehensive Prepaid Health Plans manage MH or SUD benefits; and
- Many States plan to submit a State Plan Amendment for health homes for beneficiaries with chronic conditions.⁴⁵

Medicaid Managed Behavioral Healthcare

Although many of the earliest and large-scale managed behavioral health contracts are carve outs, these carve outs are evolving and more recent developments are including somewhat rapid movement to integrated models.

Arizona has relied on Regional Behavioral Health Authorities (RBHA) to manage its 'all funds' behavioral health carveout through full risk contracts since the early 1990s. With authorization through an 1115 waiver, Arizona funnels state, federal and Medicaid dollars to the RBHAs who manage the MH/SUD benefit for Medicaid and non-Medicaid individuals. Building on the RBHA system, Arizona now intends to create a "RBHA with SMI Health Homes" in Maricopa County. The specialty RBHA would be a full-risk, fully integrated health plan for Medicaid beneficiaries with SMI; designation as a Medicare Special Needs Plan for Medicaid/Medicare dual eligible enrollees with SMI would be required and it would be prohibited from carving out either the health or behavioral health

⁴⁵ *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*; The Kaiser Commission on Medicaid and the Uninsured, September 2011.

benefits. The Specialty RBHA would coordinate care using health information technology and an electronic health record to measure system and member-level outcomes.⁴⁶

Massachusetts operates the second-oldest Medicaid behavioral health carveout and now, with Commonwealth Care, has ninety-seven percent of the state's residents covered through either MassHealth or The Connector (Massachusetts' Health Insurance Exchange). All non-dually eligible Medicaid beneficiaries are enrolled in managed care, with forty percent choosing the State's Primary Care Case Management Program that's linked to the Managed Behavioral Health Plan. For the next contract the behavioral health manager will be incentivized to increase integration across medical and behavioral healthcare, will establish a Care Management Program for high cost members with complex needs, will increase integration of mental health and substance use disorder treatment and will create an integrated medical and behavioral health delivery system. The vendor will be expected to improve screening and treatment of behavioral health conditions in primary care settings, to facilitate effective medical care for persons with SMI and to use a collaborative team approach to treatment. The MBHO will continue to administer the State's Emergency Services Program that assures statewide crisis assessment, intervention and stabilization. Similarly, the MBHO will facilitate access to the Massachusetts Child Psychiatry Access Program (MCPAP) that makes regional youth consultation teams available to primary care practitioners.⁴⁷

Given the co-morbidity and great health risks experienced by people with serious behavioral health disorders, it is not surprising that many experts believe that "integrated management of physical and mental health services for SSI beneficiaries with serious and persistent mental illness must be introduced in order to achieve better outcomes at a more reasonable cost".⁴⁸ This same analysis does note that integrated management requires strong purchasing requirements and assertive oversight by the State.⁴⁹ **Tennessee** is a State that has moved to an integrated financing model after operating a carveout for almost a decade. Believing that a State needs to integrate at the payer level first in order to support local efforts, Tennessee reports that integration has simplified contract negotiation, has eliminated 'turf wars' over which conditions are covered as physical or behavioral health and allow providers to work with MCOs to innovate and customize local care delivery.⁵⁰ With the move to integrated health plans, behavioral health utilization remained constant overall, there was an increase in some services and primary care screening for behavioral health conditions increased since referrals were easier to make.⁵¹

Kentucky has recently entered into a comprehensive risk-based managed care contract with a Managed Care Organization for management of health, behavioral, vision, dental and pharmacy services in all regions awarded by Commonwealth. The Health Plan that will manage the comprehensive benefit package is a wholly-owned subsidiary of a Managed Behavioral Health Organization.

Several states have recently begun planning or implementing new managed behavioral healthcare programs. **New York**, which has had Medicaid managed healthcare for decades, is now contracting with five regional "Phase I" Behavioral Health Organizations (BHO) that are expected to reduce inpatient admission rates, perform concurrent review of behavioral health inpatient treatment, improve rates of engagement in outpatient treatment post-hospitalization, and profile provider performance and test performance measurement systems; these BHOs hold

⁴⁶ State of Arizona Department of Health Services, Notice of Request for Information, *Specialty RBHA with SMI Health Homes*, August 16, 2011.

⁴⁷ Massachusetts Executive Office of Health and Human Services, Request for Response: *PCC Plan BHP Management Support and Specialty Services*, May 2011.

⁴⁸ *Providing Behavioral Health Services to Medicaid Managed Care Enrollees*, Prepared for the Medicaid Institute at United Hospital Fund by the Center for Health Care Strategies, June 2009.

⁴⁹ Ibid.

⁵⁰ Jeanne James, TennCare Medical Director, *Managed Care Organization as Integrated Care Entity*, Center for Health Care Strategies Webinar, *Integrating Physical and Behavioral Health: An Exploration of State Options*, November 15, 2011.

⁵¹ Ibid.

ASO contracts with the State.⁵² The Office of Mental Health and the Office of Alcoholism and Substance Abuse Services jointly procured these organizations. By April 1, 2013 Phase II BHOs will be capable of managing behavioral and physical health services to individuals with significant behavioral health needs through risk contracts. As a backdrop to the State's unveiling its Phase I effort, the State Department of Health released data showing that, when health plans manage an integrated benefit, Medicaid enrollees have fewer behavioral health admissions, lower behavioral health inpatient costs, and shorter behavioral health inpatient stays.⁵³

As a component of its recently approved 1115 waiver, **New Jersey** will be moving adult Medicaid beneficiaries with moderate and intensive behavioral health disorders into managed behavioral healthcare on January 1, 2013. Adults with less severe needs will be carved into managed healthcare beginning January 1, 2012⁵⁴. Like New York, New Jersey has long used risk-based managed care to provide physical health services to most of the Medicaid population. Under the new contract with a MBHO, behavioral health services will be coordinated with the somatic care managed by four managed care organizations. New Jersey also plans to initiate patient-centered behavioral health homes where behavioral and physical health care is integrated. Funds from Medicaid and other state and federal funds will be integrated in the managed behavioral health contract which will initially be an administrative service arrangement but will move to risk-based within a year or so.⁵⁵ For youth who are Medicaid beneficiaries New Jersey contracts with an ASO for behavioral health care coordination that is delivered through Care Management Organizations who do not deliver any direct services. The provider network is managed by the ASO.

Under its innovative inter-governmental purchasing experiment, **New Mexico's Behavioral Health Collaborative** has recently voted to transition their behavioral health carveout to an integrated model through Medicaid's *Salud!* Health Plans with protections for the behavioral health benefit. As part of its 1115 waiver planning, New Mexico will also be submitting a State Plan Amendment for health homes for individuals with behavioral health conditions under Section 2703 of the ACA.

DELIVERY SYSTEM INTEGRATION

Numerous models exist for integrating general medical and behavioral health at the service delivery level and can involve incorporating behavioral specialists into health settings, including behavioral health practitioners on integrated health teams or embedding healthcare practitioners in special behavioral health organizations.

The **Washtenaw Community Health Organization** (WCHO) was created in 1998 by the University of Michigan Health System and Washtenaw County Government. The goal was to create a medical home for everyone, with a focus on adapting disease management protocols for the population with serious mental illness. The project focuses on two target populations; the first is the group of stable consumers in the public sector who could receive care in a primary care clinic if the clinic has mental health support. The second target group includes those who are already served by primary care practitioners, but are in need of mental health consultation.

Under its *Community Support and Treatment Services*, the community mental health agency provides an onsite psychiatrist for psychiatric evaluation, consultation, and medical management. An MSW social worker is also available onsite to provide psychosocial evaluation, brief therapy, consultation, and case management. Additional services through CSTS range from medication management, crisis, individual therapy, or referral to community support services. The WCHO uses Wagner's Chronic Care Model as the underlying approach to integration. They also rely on the PACT model, McFarland's model for multi-family groups, and Minkoff or Drake's model for co-occurring mental health and substance abuse services. Continuous case management teams use wraparound services for consumers in crisis. Both the physical health and mental health components use evidence based

⁵² *Regional Behavioral Health Organization Fact Sheet*, at www.omh.state.ny.us, October 2011.

⁵³ NYS Department of Health, *Medicaid Managed Care Inpatient Mental Health: A Utilization and Cost Analysis of CY2008 Managed Care Experience*, February 2011.

⁵⁴ New Jersey's 1115 Waiver, May, 16, 2011.

⁵⁵ *Medicaid Seeks to Bring Managed Care to Behavioral Services*, NJ Spotlight, November 14, 2011.

practices to guide their work. The project has also invested heavily in an electronic medical record and in an integrated data management system that captures mental health, substance abuse and primary care utilization and treatment outcome data.

Washington State has a **Medicaid Integration Partnership (WMIP)** which is managed by Molina Health Care, an HMO, who enrolls SSI clients, including dual eligibles, into a comprehensive benefit package of physical and mental health services. Molina receives a capitated rate and is at full risk for physical, mental health, substance abuse treatment and long-term care. The MCO contracts with local service providers, including Bridgeways, a high intensity service provider utilizing a PACT model. The demonstration uses a care coordination model rather than a clinical model of integration and was informed by Wagner's Chronic Care framework as well as by Prochaska's stages of change model. The Coordinated Care Team performs an initial screening to identify enrollee risks and then monitors patients' symptoms and provides patient education; the team is also responsible for addressing all enrollee service needs. The teams are generally led by a RN with experience in care coordination and working with chronically ill populations. For enrollees with primary a mental health diagnosis, the team is led by a mental health clinician. A physician and psychologist are available to consult with the team as needed. Evaluations from the first two years of the program found that WMIP enrollees had lower rates of inpatient psychiatric admissions, improved 'fill rates' for psychiatric prescriptions, and decreased state hospital stays.⁵⁶

InterMountain Healthcare is system of twenty three hospitals serving the Utah and Idaho region. It offers a range of medical services, multi-specialty clinics and physician offices, urgent care centers, after-hours kid's clinics, homecare & hospice, lab services, imaging and radiology, LifeFlight emergency medical transportation, and occupational health clinics. InterMountain also operates its own health insurance company.

In 1999, InterMountain's leadership became concerned that its primary care medical resources were not being used effectively to treat patients with depression and other mental health conditions. A Mental Health Integration (MHI) quality improvement program was established to help physicians in managing mental health issues and to build a business case for the integration of primary and behavioral health care. At the clinical level, the role of the primary care physician, mental health provider, patient and family, and care manager were redesigned into a consultative and collaborative treatment team model to provide patient and family centered care for mental health conditions. Sustained results demonstrate that collaborative primary and mental health care leads to improved functional status in patients and improved satisfaction and confidence among physicians in managing mental health problems as part of routine care at a neutral cost.

Stanley Street Treatment and Resources (SSTAR) is a non-profit health care and social service agency providing a wide range of mental health and substance abuse treatment services to people throughout the communities of Southeastern Massachusetts and Rhode Island. In order to better address the health care needs of their patients, SSTAR developed The Family HealthCare Center. The Center is a "look alike" federally qualified health center that has expanded to a family medicine model, serving all people from infancy through adulthood. Most of their patients have encountered obstacles to care or personal situations that have required supportive services. Specialized medical services include the management of infectious diseases including the treatment of HIV/AIDS and Hepatitis C as well as a Diabetes Case Management Program. Bi-lingual Community Health Workers are available for case management and home visits.

STAKEHOLDER INPUT

In early September, 2011 DHMH's consultants on integrated behavioral healthcare held three listening sessions with DHMH's stakeholders to seek their opinions on a series of questions around integration. The purpose of the meetings was to get participants' insights on how Maryland can capitalize on health reform to create a better

⁵⁶ *WMIP Monitoring: A Data Briefing*. Washington State Department of Social and Health Services, November 2007, cited in *Providing Behavioral Health Services to Medicaid Managed Care Enrollees*, op cit.

integrated system of care, given Maryland’s current approach to behavioral health service delivery, financing and benefits management. Input at the sessions was focused on the following 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?

Comments from the audiences were wide-ranging, with some directly related to the questions posed and others covering systems issues that don’t directly relate to the questions posed. What follows is a summary of stakeholder themes and concerns.

The Current System

Both MHA and ADAA are seen as **recovery-oriented systems** and this characteristic should be maintained and strengthened. The existing strengths should be enhanced--lots of good localized efforts were mentioned, administrative overhead is small, and average cost/person is stable. Attendees identified some **“projects that work”** (e.g. Baltimore Capitation Project, Baltimore compacts for SUD treatment in corrections) and thought that they should be expanded in the future. Alternatively, some wanted a review of **what’s not working** to identify areas where the State is spending money with no effect

Managed Care

Many stakeholders expressed a lack of confidence in the **Managed Care Organizations’** ability to manage behavioral health treatment effectively. Others felt there should be no profit in the mental health system.

Data-based Decision Making

There was great support for a larger State commitment to **gather data, analyze it and report it**, especially in terms of comparative evaluations of the benefit management systems across Medicaid, ADAA and MHA. Participants encouraged the state to use data that’s already collected, not to create additional reporting requirements.

Clinical Practice

Many attendees noted that discussing **clinical practice** is more important than administrative structures although others expressed support for the administrative integration that DHMH is undertaking. Several supported a universal approach to **motivational interviewing**, stages of change, and stage-wise treatment. The State has to make some decisions on where it stands at the practice level and create strategies to incentivize it. A greater focus on **‘family-centered care’**, not just patient-centered, was recommended. Family systems work needs a new funding model so that both the youth and the family can receive appropriate treatment.

Integration of Mental Health/Substance Use Disorder (MH/SUD) Treatment

While many stakeholders thought there was movement on MH/SUD integration, some still identified the need to **reconcile the differences** across MH and SUD, e.g. prominence of criminal justice for addictions, not as important for mental health. There is also still work to be done on **cross-training and credentialing** SUD counselors to treat MH and MH clinicians to treat SUD. Participants asserted that there was uneven knowledge across MH and SUD practitioners about patients with co-occurring disorders.

Integration with Health Care

Although some participants identified alignment with **FQHCs** as critical (e.g. putting behavioral health specialists in clinics as well as case managers and peer specialists), others wanted to make sure that **non-FQHC** primary care practices were also offered options for integration. Since most behavioral health treatment occurs in primary care, many stakeholders felt that **primary care** needs to be able to do SBIRT, depression treatment, etc. and be reimbursed for it. Stakeholders wanted to know what the state’s view of **integrated care** was: how would it save

money? Who would be in charge? Many spoke of the **advantages** of integrated care in comprehensively assessing clients' needs in one place; practitioners have the time to do this and are compensated for it; they work as a team; communication is open, records are integrated; there is high patient involvement. A suggestion was made to take a cohort of consumers and follow them through integration (like "Nielson families"). **Electronic Health Records** (EHR) that are combined for mental health and substance use (MH/SUD) disorder treatment were identified as being critical and the fact that the behavioral health provider community needs to be included in **Health Information Technology** development. Many identified the need for a statewide approach to address **confidentiality** concerns, especially 42 CFR.

Health Reform

Participants wanted to ensure an ongoing State commitment to an **adequate provider network** in terms of type of providers and availability of services and capacity to accept patients. Medical homes should be one of the options for improving health outcomes and the State should pursue a State Plan Amendment for **Behavioral Health Homes**. Many stakeholders felt that implementation of **parity** requires much more oversight than it is being given. Even with expanded coverage in 2014, the State will still need **safety net dollars** for enrollment gaps, those who remain uninsured, special services, etc. The ability to have a **continuum of services** was seen as essential, e.g. offsite PRP, residential treatment, and state hospital beds. Block grant funds have allowed addictions to retain a full continuum of services (e.g. ASAM 3.5, 3.7) and attendees wondered whether this be retained. **Wellness and recovery centers** (peer employment resource centers, addictions counselors, WRAP) need to be included as part of the treatment plan and Medicaid billing. The system needs to pay for **prevention and early intervention**, housing, school-based health centers, innovative funding to leverage local dollars and increase access, especially for special populations. Many expressed the need for a **comprehensive crisis system**. Telehealth and teleassessment must be available outside the community mental health clinics and include addictions providers. The public behavioral health system can't just focus on fee-for-service reimbursement but must also retain some **flexibility to deal with gaps** in the service system.

Services

Attendees wanted to make sure that **special populations** were addressed in the system of the future: children, seniors, individuals with developmental disabilities; criminal justice/corrections, nursing homes and that **specialized services** received attention (e.g. home-based integrated care for the aging population, ACT, trauma-informed care, peer specialists, case management for those with substance use disorders); transportation was a concern as well.

Workforce

Workforce development issues and needs were seen as critical to address diverse populations and expand access to meet demands. Support was expressed for a continued role for the state in **training and education**, with a sustainability model for training, supervision, and evaluation. **Learning collaboratives** were seen as a good model to create ways to share knowledge across MH and SUD and to sustain the knowledge. Graduate level training was identified as needing improvement (integration, family systems) to produce "integrated clinicians".

Financing

Significant numbers of stakeholders recommended that DHMH review all **authorization and billing rules** for both the Administrative Service Organization and Medicaid's Managed Care Organizations to evaluate their support of good clinical practice, including integrated treatment for co-occurring psychiatric and addictive disorders. Requirements that don't foster integration and best practice should be revised or eliminated. Many thought the State could save money by **blending and coordinating funding streams** to meet 'whole person needs', especially for children. **Reimbursement** systems needs to pay for team meetings, exchange of information and other non-direct treatment support.

Financing mechanisms need to recognize Mental Health and Substance Use Disorders (MH/SUD) as chronic conditions and reimburse accordingly. Payment should align **incentives** with values and desired outcomes; the public behavioral health system should develop a short list of outcomes and begin "buying" them. Some thought a focus on **high utilizers** of behavioral health services could produce a high return on investment. There was

disagreement as to whether the State should mandate **Evidence-Based Practices** or allow providers to choose which to adopt and then provide differential reimbursement for EBPs which are seen by some as financially prohibitive to deliver. Some recommended the use of **science-based evidence** for opiate treatment; other SUD providers did not want the state to dictate the use of medication-assisted treatment.

Local Authority

Support was expressed for a certain degree of **local autonomy**. Jurisdictional oversight was seen as important since not all funding decisions can be made “from a distance”. Geographic differences should be acknowledged in creating **regional delivery systems** with different capacities.

Continued Stakeholder Involvement

Many stakeholders wanted more public discussion around the **State Medicaid Plan** and a better understanding of its components and requirements. Participants wanted DHMH to develop a plan for helping **consumers and family member** understand all these changes and need to listen to grass roots consumers, not just organized advocates. Some attendees thought DHMH should begin conversations with the MCOs around behavioral health benefits management. Several participants made a special request that the consultants hold another round of listening sessions after the integration options were identified but before the final report was distributed.

After DHMH posted the draft “Options Paper” on the Integration web site, the consultants held two more stakeholder meetings to receive input on the options in mid-November, 2011. Discussions during these meetings were much more focused than the first round, with stakeholders both asking questions and expressing opinions on future models for integrated benefits management and care. Summary themes and concerns were as follows.

While there was support for **integrating MH and SUD treatment**, concern was expressed about **integrated management** of the general medical and behavioral health benefits. Participants were concerned that the MCOs would not give **prominence to the behavioral health benefit**; there should be no incentives for rationing care; and any savings should be returned to providers. Some stakeholders thought the move to a **risk-based behavioral health carveout** would be positive but others asked whether it would be harder to **assure parity** with this approach. Participants thought that any risk-based approach demanded **strong performance standards** and a requirement for a **minimum Medical Loss Ratio**. There was significant support for either the development of **health homes for people with serious behavioral health conditions** or the addition of behavioral health services to the existing MHCC medical home pilot. Some thought there should be a **carveout solely for individuals with serious behavioral health disorders** and that these individuals should be able to opt out of the Medicaid MCOs. Those supporting integrated care with separate benefits management recommended that **risk be shared** across the MCOs and the ASO for the development of medical homes on the health side and clinical homes for behavioral health recipients. **Workforce development** was emphasized as a critical issue in terms of numbers, levels of training and licensing issues. **Staff certification** was cited as a barrier to integrated MH/SUD treatment since there is certification for bachelor’s level staff for SUD treatment but none for MH providers. Participants also noted the need for a better crisis response system. Other comments from the session included: interest in clarifying the **roles of local health departments** relative to managed care entities; interesting in identifying **strong MCO performance standards** from other States, and phasing in and reviewing **contractual performance standards** annually over the life of a contract. Several participants were concerned about the future of existing **provider-owned, locally-based managed care organizations** if Medicaid moved to selective contracting.

VISION OF AN INTEGRATED SYSTEM

As Maryland considers the paths it will take to move to integrated delivery systems and payment mechanisms for behavioral health and somatic care, there is a set of core overriding principles that should be followed in crafting both the final and intermediate design. The ultimate goal is to integrate the care of the whole person in one comprehensive system of health care services. This can be accomplished in a series of steps, evaluating progress toward the overall objective at each phase of the process of policy and practice implementation. It is possible that functional integration of care of the whole person will not be served best by complete organizational or financial

integration within the system. Identifying integrated care as the endpoint objective allows a set of principles to be followed along the path to integration.

With regard to integrating behavioral healthcare we recommend 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.

POSSIBLE OPTIONS FOR INTEGRATED CARE

Delivery Platforms

Like other states, Maryland's public behavioral health system contains a variety of outpatient and specialty care providers, e.g. residential, partial hospitalization, intensive home-based services, etc. While the public system of the future will still need both types of provider organizations, given the coverage expansion envisioned by the Affordable Care Act, increased availability of outpatient services will be required to create access for newly eligible Medicaid beneficiaries and for individuals whose coverage is subsidized through the Health Insurance Exchange. Consequently, Maryland should begin to encourage a delivery platform that is behavioral health 'user friendly', creates easy access to both mental health and substance use disorder treatment, that possesses the clinical capability to treat both conditions and to provide effective consultation to the primary care or specialty medical system.

As Maryland develops its integrated care system, it should assume that the majority of publicly-financed behavioral health benefits will be delivered through two practice models and delivery platforms:

Community Behavioral Health Organization⁵⁷

- Capable of providing outpatient and intensive outpatient services, case management/community support, recovery/health coaching, medication-assisted treatment and crisis response for individuals with either mental health and/or substance use disorders, including individuals with co-occurring disorders and those with serious mental illness or serious emotional disturbance;
- Employs a mix of licensed professionals (both those able to practice independently and those practicing under supervision), paraprofessionals (e.g. health coaches) and peer specialists;
- Has consultant-liaison physicians to primary and specialty medical care (psychiatrists, ASAM physicians, or internists) and telehealth capacity;

The community behavioral health organization will be capable of sophisticated diagnostics and assessment, offer urgent care access, be expert in short-term specialized therapy and treatment and provide long-term resilience support for youth and families and long-term recovery support for adults. All staff will be expert in motivational

⁵⁷ Identification of a Community Behavioral Health Organization as a core provider of outpatient level of care does not eliminate the need for specialty providers that would offer more intensive and specialized services like SUD residential treatment, therapeutic foster care, ACT, etc.

interviewing.⁵⁸ It will have effective systems of communication with primary care and will provide responsive support to primary care practitioners. Collectively, community behavioral health organizations will form the backbone of a statewide, universally accessible crisis response system.

DHMH's current work on *Behavioral Health integrated Regulations* will result in the alcohol and drug abuse and mental health provider systems using one set of standards to govern the provision of service, eliminating the separate silos of mental health and addictions treatment and allowing provide organizations to seamlessly deliver either component of behavioral health care.

Primary Care Practice (Primary Care Practice, Federally Qualified Health Centers [FQHC], Rural Health Clinics [RHC])

- As is true now, primary care will continue to provide the majority of behavioral health treatment, especially for conditions like depression,⁵⁹
- Many patients will prefer to receive behavioral health treatment within primary care and many primary care practitioners will feel comfortable providing this care; and
- The quality of behavioral health treatment delivered by primary care will be enhanced by the availability of clinical and medical consultation from specialty practitioners.

Primary Care will screen for behavioral health disorders; treat depression, anxiety and other mild/moderate behavioral health conditions; and link to and coordinate treatment with specialty providers (including behavioral health). Screening, Brief Intervention and Referral to Treatment (SBIRT) will be available in primary care settings. It may provide long-term medication-assisted treatment for behavioral health conditions, and will motivate patients to be managing partners of their care through education and patient activation. While primary care practitioners may routinely refer individuals with serious behavioral health disorders to specialty behavioral health care, some of these patients may choose to remain in primary care settings.

Community behavioral health organization may choose to create more robust systems of integrated care by becoming a Health Home, by incorporating healthcare practitioners into their clinical operations, or by co-locating behavioral health specialists within healthcare settings. Primary care practices may collaborate more closely with behavioral health by becoming a Patient-Centered Medical Home, by affiliating with behavioral health practices, or by co-locating health specialists within behavioral health settings.

Special Delivery Systems

In a variation on Patient-Centered Medical Homes and Health Homes, Maryland could create a chronic care medical home pilot for medically and behaviorally complex patients. Such a medical home would integrate somatic and behavioral healthcare through affiliations between primary care practices and community behavioral health organizations. The practices that are participating in the Maryland Health Care Commission's medical home pilot or Federally Qualified Health Centers would be good candidates for partnerships with specialty behavioral health providers for this project. This pilot could be guided by both accreditation standards for Patient-Centered Medical Homes and CMS' guidance on Health Homes. Piloting the model could inform Maryland's eventual submission of either a State Plan Amendment for Health Homes or its continued expansion of Patient-Centered Medical Homes that had a strong behavioral health component. Maryland could also tailor its CME system to be behavioral health homes for youth with complex needs and create linkages between the CMEs and the MHCC's medical homes.

⁵⁸ Motivational Interviewing is singled out as an especially important Evidence-based Practice because of its growing prominence in primary care; because it can used in all treatment types and modalities; and because it is relatively easy to train staff in its use.

⁵⁹ Croghan, TW, Brown, JD. *Integrating Mental Health Treatment into the Patient Centered Medical Home*. Prepared by Mathematic Policy Research under Contract to the Agency for Healthcare Research and Quality, June 2010.

As part of its managed care design, Maryland could allow Health Plans to incorporate either ‘specialty’ or comprehensive Accountable Care Organizations (ACO) into their provider network. A specialty ACO might bundle a behavioral health system of care and include inpatient and outpatient mental health and substance use disorder providers while a comprehensive ACO would include all primary and specialty medical treatment as well as behavioral health care. ACOs would likely be contractors to Health Plans in first phase implementation but might take risk directly from the public purchaser in future iterations.

Benefits Management

Given the state of the art in Medicaid purchasing and benefit management, there are a range of models for Medicaid purchasing and benefit management. The range includes three main approaches:

1. Re-scope or re-procure the *Administrative Service Organization* contract to include the Medicaid and uninsured SUD benefit, enhance the functions and add performance risk to the contract.
2. Selectively contract with a behavioral health only *Prepaid Health Plan* whose functions parallel those of the HealthChoice Managed Care Organizations and that bears both insurance and performance risk for Medicaid beneficiaries.
3. Selectively contract with ‘full benefit’ *Managed Care Organizations* to manage both the health and behavioral health benefits.

The special delivery systems described in the previous section could be embedded in any one of these purchasing and benefits management options.

In targeting specific options for Maryland’s review, consideration was given to an assessment of Maryland’s current approach to benefits management and service delivery, the environmental scan of other States’ approaches and the new opportunities for delivery system reform.

ASSESSMENT AND RECOMMENDATIONS

Principles for Promoting Integrated Care

As Maryland moves to a more integrated system of care, the following principles/specifications are recommended:

- Provide consumers with an experience of holistic care for general medical as well as behavioral health conditions; avoid silos, difficult-to-follow transitions and handoffs; and fragmented and episodic care experiences.
- Look for all opportunities to move to greater integration of benefits, financing and delivery systems between MH and SUD and across behavioral health and general medical care. Specifically:
 - Standardize basic benefits for MH, SUD and related health conditions for Medicaid and uninsured programs;
 - Contract with providers capable of delivering integrated behavioral health and coordinated primary care services;
 - Coordinate the purchase of integrated behavioral health and primary care services.
- Establish incentives to promote efficiency while avoiding under-treatment and cost shifting.
- Have all components of the publicly-insured behavioral health benefit managed by the same entity.
- Increase Medicaid’s purchasing power and accountability for benefits management and clinical care through greater emphasis on performance and a stronger contracting process.
- Create incentives for general medical and behavioral health plans and providers to collaborate clinically by establishing shared risk for health outcomes for specific populations.
- Assure that all authorization and billing policies and practices support good clinical practice and integrated care.

- Include standards for MCOs that will encourage provider integration and forms of provider payment that facilitate patient continuity, provider control and efficiency, and provider risk/benefit sharing.
- Increase the transparency of Health Plan performance through regularly-issued “report cards” that evaluate access, penetration and utilization for both primary and specialty behavioral health care with comparable data analyzed in a consistent way.
- Looking forward to ACA requirements, control the opportunity for Health Plan profit through the establishment of a minimum Medical Loss Ratio for Medicaid MCOs.

Assessment of the Current System of Behavioral Health Services

Maryland’s system of behavioral health services possesses strengths that can smooth its path to a more integrated system. The mental health community has had almost fifteen years experience with managed fee-for-service; addictions treatment providers have now gained some experience with fee-for-service reimbursement; access to addictions treatment was increased with the Medicaid expansion through PAC; and the Children’s Cabinet has established a specialty delivery system for a targeted group of children with complex behavioral needs.

There are also a number of limitations and problems with Maryland’s current system for financing, benefits management and service delivery. The most glaring limitation is the fragmentation of the behavioral health service system between MH and SUD treatment and the lack of connection with general medical services. This occurs because of poor alignment of benefit design and management, purchasing and financing, care management and the management of performance and risk. These features result in a less than optimal patient experience and interfere with the State’s ability to maximize its purchasing power to achieve the triple aim of improved patient experience, improved population health and reduced costs. These features include the following.

Benefit Design and Management are Poorly Aligned

- The Medicaid mental health benefit is carved out; the Medicaid addictions benefit is carved in.
- There is little alignment among the various publicly-financed benefit packages.
- There is no connection between benefits management for health and mental health.
- There is likely no coordination of benefits across Medicaid and services for persons who are uninsured since this function is not included in the ASO contract and the ADAA ‘benefit’ is locally determined through allocations made to local health departments.

Purchasing and Financing are Fragmented

- There are multiple, disparate public funding sources, purchasers and payers, with State level purchasers including Medicaid, MHA, ADAA and local funders including CSAs and local health departments as well as child- and family-serving funders including the Children’s Cabinet Interagency Fund, juvenile justice, child welfare and education.
- There is little coordination between the purchasing of the State and counties using block grant and state/county appropriations and Medicaid’s purchase of behavioral health services.
- The mental health benefit for people who are uninsured is reimbursed on a fee-for-service as a companion to the Medicaid mental health benefit; addictions funding for people who are uninsured is grant-funded through allocations to local providers or health departments.
- The mental health benefit for people who are uninsured is defined and parallels the Medicaid benefit; the addictions benefit for people who are uninsured is locally determined, although allowable categories of service are specified by the state.
- Medicaid’s approach to selecting health plans through regulatory compliance may not provide the State with maximally strong purchasing power.

Care Management is Not Coordinated

- Both the ASO and CSAs authorize mental health services.
- Medicaid’s MCOs and ADAA use ASAM criteria for level of care determinations; the ASO uses no equivalent level of care determination system (e.g. LOCUS).

Performance and Risk is Lacking

- There is no performance risk in the Medicaid mental health managed fee-for-service system.
- There is only a small amount of risk for MCOs through Medicaid’s Value-based Purchasing.
- There is no performance risk for MH or SUD providers and, therefore, little financial incentive to coordinate or follow up on patient care.
- There is no attention in the ASO contract to serious system problems, e.g. ED presentations, 30-day readmissions, coordination with MCOs, etc. and assignment of risk for remediating them.
- During the fourteen years that the Specialty Mental Health System has functioned, expectations and deliverables for the ASO have not substantially changed or been used to improve system performance.

Integrated Care Needs Improvement

- There is limited activity on integrated care management across the MCOs and the ASO; MCOs do not routinely receive mental health utilization data on persons enrolled with them. Given this fact, there can be no coordinated efforts to improve the health status of Medicaid beneficiaries with co-morbid health conditions.
- Since the contracts for the MCOs and the ASO are separately issued, there is no opportunity to require shared risk for performance standards, including improved health status.
- There are no formal contractual expectations for effectively integrating care, either in the MCOs or the ASO; there are also none at the provider level. This applies equally to MH and SUD integration and for behavioral health and somatic integration.
- There is no designated site of clinical accountability for persons with serious behavioral health conditions.

Recommendations for Integrated Behavioral Health Benefits Management

Recommendations for Maryland’s advance to 2014 are based on the experience of other States, input from stakeholders, lessons learned from managed behavioral healthcare and advances occurring in the health care sector. More importantly, these recommendations are based on what is known in the year 2011 about Medicaid beneficiaries and those who depend on the public behavioral health system for services:

- Co-occurring psychiatric and addictive disorders are the expectation, not the exception⁶⁰;
- Fifty percent of Medicaid beneficiaries with a disability have a psychiatric illness⁶¹; and
- Annual Medicaid per capita health costs are three to four times higher for disabled beneficiaries who have co-occurring behavioral health conditions.⁶²

While the ASO model has served Maryland’s mental health system well for more than a decade, the national movement toward integration and the use of risk to incentivize clinical outcomes would indicate that this may not be the preferred model for the future. Most States are using a risk-based contractual model as the platform for incorporating PCMHs, Medicaid Health Homes, and integrated delivery systems. Further, since Maryland’s ASO manages only the mental health benefit, significant changes in its scope would be required to integrate SUD benefits; removing the Medicaid SUD benefits from the MCOs at this point could disrupt the gains in access made with the PAC expansion. Having legally-required parity across general medical and behavioral health benefits presents an opportune time to attempt to use a more holistic approach to managing care for persons with co-

⁶⁰ Minkoff and Cline, op cit.

⁶¹ Kronick, et al., op cit.

⁶² Boyd, op cit.

morbid medical and behavioral health conditions. The use of a MH-only ASO does not easily support the State's goals of integration and improved clinical outcomes.

For these reasons DHMH should consider the following recommendations for system improvement, coinciding with the implementation of the Affordable Care Act in 2014.

Option 1

By 2014 have at least the Medicaid behavioral health benefit managed by Health Plans through a "protected carve-in". Through a strong, performance-based selection process, Medicaid would contract with Health Plans to manage a comprehensive benefit package of general medical and behavioral services. Health Plans would receive a separate, dedicated behavioral health capitation rate that could only be spent on behavioral health treatment and recovery support. Any savings would be re-directed to additional, innovative behavioral health benefits. Contractual conditions would require the Health Plans 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 plans 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 Health Plan 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.

Consistent with this, Health Plans would be required to provide DHMH with specific data that demonstrates its effective management of the behavioral health benefit. These data would include:

- Penetration rates: number of persons with behavioral health diagnoses receiving behavioral health services (MH, SUD, MH&SUD, and total) by age groups, regional areas, etc.
- Expenditures for behavioral health services by MH, SUD, MH&SUD and total by level of care
- Expenditures for all other medical services for these same diagnostic cohorts by type of care: outpatient, inpatient, emergency room, etc.
- Specific analysis of enrollees identified as high cost/high use/high need (in the diagnostic cohorts identified above)
- Specific analysis of behavioral health authorization denials

This option has the advantage of accelerating the pace of integration while protecting the behavioral health benefit. 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.

It would also be desirable to have these same Health Plans administer the behavioral health benefit for persons who are uninsured (those who remain ineligible for either Medicaid or subsidies through the Exchange) and for Medicaid beneficiaries who meet clinical necessity criteria for the State/block grant-funded benefit package. Non-Medicaid funds will also be necessary to cover enrollment gaps, either during the time an individual is first enrolled, lapse in eligibility or transition between Medicaid and Exchange subsidies. Having a single Health Plan also manage these funds could make beneficiaries access to interim coverage and urgently needed treatment more seamless. This recommendation assumes that the State would specifically define the benefit package it will offer for individuals who are uninsured and for individuals who may be ACA-covered (either Medicaid or the Exchange) but who need treatment that's outside the Essential Health Benefit. If these funds are managed outside the Health Plans, the State will need to develop a strong Coordination of Benefits system in order to avoid cost shifting from plans that are at risk back to State/federal-only funding.

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 Plans (BHP). Using a competitive selection process, Medicaid would contract with a BHP that would bear both insurance and performance risk. Contractual conditions would be aligned with those of the Medicaid Health Plans; performance standards would be robust and performance risk would be shared with Health Plans 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.

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.

Given the managed behavioral health industry's experience with managing non-Medicaid funding, it would be highly advantageous for the BHP(s) to administer the behavioral health benefit for persons who are uninsured (those who remain ineligible for either Medicaid or subsidies through the Exchange) and for Medicaid beneficiaries who meet clinical necessity criteria for the State/block grant-funded benefit package. Non-Medicaid funds will also be necessary to cover enrollment gaps, either during the time an individual is first enrolled, lapse in eligibility or transition between Medicaid and Exchange subsidies. Having a single organization also manage these funds could make beneficiaries' access to interim coverage and urgently needed treatment more seamless. This recommendation assumes that the State would specifically define the benefit package it will offer for individuals who are uninsured and for individuals who may be ACA-covered (either Medicaid or the Exchange) but who need treatment that's outside the Essential Health Benefit. If these funds are managed outside the BHP(s), the State will need to develop a strong Coordination of Benefits system in order to avoid cost shifting from plans that are at risk back to State/federal-only funding. [Same recommendation as for Option 1.]

Interim Steps to Achieving Integration with any of the Options

Although the draft Options Paper included two possibilities that build on the current MHA ASO, these are not recommended for several reasons. Given the increase in access to addictions treatment achieved in the Medicaid expansion through PAC, it would be step backwards to carve out the SUD benefit, only to carve it back in within a relatively short period. There would be significant State effort required to either re-scope or re-bid the ASO contract; this effort would be better spent on creating a blueprint for integrated benefits management and care.

In the interim, DHMH would continue the current system of Medicaid behavioral health management for the next two years: the SUD benefits would be managed by the MCO and the MH benefits by the ASO. The State should add performance risk to the ASO contract with the September 1, 2012 renewal. Concomitantly, performance risk should be increased for the MCOs as soon as Medicaid is able to, given the final State decision on selective contracting. Assuming that the two contracts can be synchronized in 2012, they should contain a few powerful performance standards for which risk is shared by the MCOs and the ASO as well as the requirement that utilization data be exchanged for individuals enrolled with the MCOs and receiving MH services authorized by the ASO. In the next ASO renewal, the State should require the ASO to propose and receive State approval for a specific level of care determination system for MH and/or SUD service authorization that is compatible with ASAM.

Development of an implementation plan for 2014 should be informed by more specific data analysis referenced earlier in this report (Medicaid data on utilization of behavioral health in primary care settings, expenditure patterns for primary and specialty behavioral health services, as well as expenditures for major categories of those

services, etc; MHA and ADAA data on services purchased for persons who are uninsured.) Use of these data in Maryland's planning for the future will increase the likelihood that the State's plan for integrated benefits management and care will improve health outcomes for those individuals receiving State-financed behavioral healthcare. These additional data are not required to make a decision about policy options at this point in time but will be important to guide the successful implementation of the selected policy.

Given the dramatic growth in patient-centered medical homes across the country and in State Medicaid programs, DHMH should add the development of health homes as a contractual obligation for the MCOs and the ASO in this interim period; the State could attach risk to this requirement. Based on strong data analytics, the State should identify the populations who are first priorities for health home enrollment. If the State decides to submit a State Plan Amendment under the ACA for health homes, it could use this same approach for enlisting the MCOs' and ASO's assistance in their development. As another interim step toward integration, the State could create a demonstration project to establish health homes for people with behavioral health conditions and require the MCOs and ASO to partner with DHMH on this initiative. Community mental health and/or additions providers or Federally Qualified Health Centers could be identified as eligible for health home designation for this population.

As part of ACA implementation, the State should align contracting/certification requirements and processes across Medicaid and the Health Insurance Exchange in order to create a high degree of overlap across Medicaid's MCOs and the Exchange's Qualified Health Plans. In this way, families with children could potentially participate in the same plan and provider network, even if the adults' coverage was subsidized under the Exchange and the children were covered by MCHP. Individuals whose economic status changed from year to year could also experience stability in their health plan and provider.

CONCLUSION

The options for Maryland's path toward integrated behavioral healthcare presented in this paper represent delivery platforms and benefits management models that are likely to assist the State in both integrating care at the clinical level and in using risk contracting to facilitate that integration. The options are consistent with the principles of integrated care and are based on a review of the current system in Maryland and an evaluation of models from other States.

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