

Maryland Mental Health Coalition

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Charles J. Milligan, Jr.
Deputy Secretary, Health Care Financing
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Deputy Secretary Milligan:

We are in receipt of the Department of Health and Mental Hygiene's draft recommendations to integrate public behavioral health service delivery in Maryland. Thank you for the many opportunities afforded over the past four months to participate in the process of system restructuring. We have reviewed the recommendations and participated in public discussion regarding the proposed plan. The 100 undersigned organizations are united in support of Model 2 as the best avenue to improve care, efficiency and outcomes for the public at this point in time. **However, for the reasons enumerated below we are also unified in our support of a risk-based administrative services organization (ASO) as the best vehicle to achieve the goals of full integration of behavioral and somatic health care service delivery and elimination of stigma with respect to the treatment of mental illness and substance use disorders as we move incrementally toward the possible adoption of an MBHO model with full insurance risk.**

1. **Cost** – Contracting with a for-profit MBHO will cost approximately 10% of the community services budget or \$65 million, more than six times the \$10 million cost of the current ASO contract. The system cannot afford to lose an additional \$55 million in service dollars to feed an expanded administrative structure.

Second, there has been no discussion over the past four months or analysis shared of the cost of this potential contract versus the expected savings that would result from the contract. There is no point in removing tens of millions of dollars from service delivery if the amount to be saved does not exceed the cost of the contract.

Given the amount of cost containment that has already occurred in the public mental health system (PMHS) in recent years with minimal disruption to end users, it would appear that Maryland's PMHS is doing an enviable job in managing cost. It can do better. With expansion of performance based financing, it will. As stakeholders we respectfully request the opportunity to review the expected fiscal results of the proposed MBHO fiscal model, as this proposed change holds the potential for profound impact on the lives of tens of thousands of individuals served by the public behavioral health care system.

2. **Efficiency** – Maryland's PMHS, managed by the Mental Hygiene Administration in partnership with local mental health authorities and a contracted ASO, has proven effective in managing per capita cost, with per capita public mental health service cost **currently below 2003 per capita spending levels**. Community mental health providers have seen their rates increase by less than 4% since FY 2006. Increases for MCOs, meanwhile, have totaled more than 30% during the same time period.

The PMHS reports administrative costs of 3%. The proposed MBHO contract will cost the State approximately 10% of the community services budget, or \$65 million. The numbers speak for themselves.

3. **Capacity and Flexibility** – It has been argued that outsourcing to an MBHO is necessary because of the flexibility in provider payment options afforded through such an entity. However, Maryland's PMHS is already moving forward with performance based financing options on a pilot basis and is poised to expand these projects as outcomes are assessed. We are anxious to work collaboratively with Medicaid to build on these efforts and look forward to participating in stage 3 efforts to share effective designs for expansion of flexible payment options within the ASO financing structure.

One of the significant barriers to flexible funding arrangements within the PMHS has been the rigidity of the Department's MMIS system. However, we are told that Medicaid is on track to roll out the long awaited new eligibility system in 2014, and that this upgrade will increase the sophistication of the system, enable flexible financing arrangements, and address many longstanding concerns. This schedule meshes well with the timeline for further expansion of performance based financing within the PMHS and should further alleviate some of the financing barriers the PMHS is already moving forward to alleviate.

Secondly, and as we have stated in prior correspondence, an incremental approach to establishing case rates and/or full capitation is required given the following: state information technology limitations, the lack of necessary data to properly set rates on a statewide basis, the lack of models with proven success in other states, and the potential risk to vulnerable populations of moving forward without these capacities in place. Maryland's efforts to address the addiction treatment needs of the public through capitated financing has had less than satisfactory results over the past 14 years, given that half or less of Health Choice recipients in need of addiction treatment have been able to access such care, according to the Department's own analysis. Given the evolutionary nature of capitated financing mechanisms for specialty behavioral health services, it seems risky at best to decide now that such an approach will best serve individuals living with serious mental health and addiction treatment needs, without first analyzing the results of carefully designed and evaluated pilots of the proposed financing method.

Finally, a cautionary note with respect to service capacity. Over the past three decades the managed behavioral health industry has evolved with a primary focus on the short term behavioral health needs of individuals covered through commercial insurance policies. The experience of this industry in managing the financing and delivery of care for individuals with serious behavioral health conditions is limited and evolving. Commercial coverage for such care remains woefully inadequate, despite Congressional efforts to improve the situation through passage of the 2008 Mental Health Parity and Addiction Equity Act. By contrast, Maryland's PMHS has evolved over many decades with a primary focus on serving individuals with complex needs. We agree that a system led by experts in the treatment of these complex illnesses that partners with private sector partners offers the opportunity to blend the strengths of both sectors. However, given the limited experience of private sector partners in serving those with the most serious needs, demonstrated results should precede the leap to a full risk contract.

4. **Alignment of Partners** – An advantage of the MBHO structure is the ability to create direct relationships between the system manager and providers of care through creation of a contracted provider network, while balancing the very real problems which exist with respect to adequate levels of choice and access, particularly in rural communities. We believe the goals sought through

this type of direct relationship can be similarly achieved in an ASO structure. In earlier correspondence we suggested a first step that can be accomplished now in this regard. Creation of a preferred provider network would enable a closer relationships between provider and manager, align the provider network toward desired goals, eliminate administrative burden for providers who achieve key benchmarks, and most importantly, preserve service delivery capacity over the next several years so that we are prepared to respond to the growth in demand that will occur as the number of insured lives increases as a result of health care reform. This is not unlike the preferred provider status for treatment of foster care that has been established and effectively used by the Department of Human Resources. With a preferred network in place, the system will be poised to take next steps that make sense several years down the road in a newly aligned health care landscape.

5. **Cost of Transition** – In addition to the fiscal cost of the contract, there will be substantial cost in transitioning to a new system. Service providers will be required to divert an increased amount of scarce resources to administration. Addiction treatment providers report a substantial increase in administrative costs resulting from the recent PAC expansion. Additionally, despite our best efforts in planning, there will be unintended service disruption for some consumers as relationships change among providers, the new contractor and the Department. To our knowledge, there has been no calculation of the net cost of these service disruptions or increases in administrative burden.
6. **Coordination of Care** – We concur with the Department’s view that Model 2 will best address the broad spectrum of care coordination and collaboration goals at this point in time. Integration of mental health and addiction treatment financing will be achieved under Model 2. The health home initiative set for implementation in 2013 represents an important step toward achieving care integration across somatic care, addiction treatment and mental health services for individuals with the highest need.

However, there are several critical areas of coordination for which the risk-based ASO model offers a clear advantage over capitation to an MBHO:

- a. *Interagency Collaboration* – Collaboration across a wide range of state and local government agencies: social services, area agencies on aging, criminal justice, education and vocational rehabilitation, etc. is required to effectively serve individuals with complex behavioral health needs. As the PMHS has evolved and recognition of the critical importance of interagency partnership has grown, much time and effort has been expended in recent years to build relationships across these various domains. Interagency efforts funded through Maryland’s five year federal mental health transformation grant are realizing significant advances in children’s mental health service delivery, the interface between behavioral health and corrections, and other areas. These issues are particularly critical in the delivery of child and older adult services, given the unique needs of these populations. All of these existing relationships will need to be reestablished if an MBHO carve-out occurs, which is far easier said than done. The report notes that the system will “create a single point of accountability and coordination to link Medicaid-financed behavioral health services with these other agencies, programs and services.” The Mental Hygiene Administration already serves effectively in this role and is able to coordinate with its state and local government agency partners on Medicaid, as well as equally important non-Medicaid service issues.

- b. *Coordination Across All Payors* – The current reform effort is focused on the Medicaid program. More than 11,000 individuals also receive public mental health care as Medicaid ineligible or grey zone recipients. Some of these are children whose families have private insurance. A risk-based ASO managed system would serve all individuals regardless of payor. The report makes a suggestion that over time a single MBHO could be contracted to serve all consumers in the future: Medicaid beneficiaries, dual eligibles, Exchange enrollees and commercial insurance consumers. There is obvious benefit to consumers in such a long-term scenario with respect to continuity of care, and gradual elimination of disparities in coverage within the commercial and Medicaid markets. However, these changes will take significant time, and there is also great risk in creating a behavioral health monopoly, particularly given the limitations of oversight agencies at the state and federal levels that are charged with protecting the interests of the public. In the short run, an MBHO carve-out focused on the Medicaid program will likely disrupt the cross payor coordination that currently exists in the PMHS.
7. **Data to Inform Decisionmaking** – A significant achievement of the ASO managed mental health system is the ability to secure comprehensive systems data on a real time basis to conduct analysis, identify trends and inform decisionmaking. Maryland has used these data to launch a nation-leading outcome measurement system that is readily available to the public via the internet. By contrast, the outsourcing of addiction treatment services to private sector entities has posed and continues to pose formidable challenges with respect to the accessibility of comparable data on the addiction treatment side of the equation due to proprietary concerns of the vendor.
8. **Oversight** – The adequacy of oversight functions within DHMH is a chronic problem. With many longstanding unmet service needs throughout the health and human service system, it has been a challenge, even with broad stakeholder support, for DHMH to garner adequate resources to carry out these critical roles. Time and time again, legislation is passed to improve oversight of the health and living conditions of vulnerable individuals, only to hear years later that DHMH was only able to carry out a small percentage of the required inspections or other functions due to budget constraints. The added reality that the current gubernatorial administration will not be in place to assure their vision is achieved when the proposed behavioral health system transition occurs exponentially increases our concerns in this area.
9. **Future Negotiating Power of the State** – The move to fully outsource public behavioral health service delivery will remove expertise in the execution of the service delivery system from state and local government. Staffing and capacities lost within government are not easily restored. The State becomes dependent and often less able to analyze the actions of its contractor. Smart business practices on the private sector side assure that critical information remains proprietary. Over time, these dynamics put the State in a vulnerable position in negotiating and monitoring contracts.
10. **Singularity of Purpose** - A state run system is not without its challenges, but it is centrally focused on one goal: assuring the needs of the public are met, without the distraction and sometimes conflicting goal of securing profit from a health care system serving vulnerable individuals whose needs remain difficult to predict. Achieving this central goal, without distraction, is what stakeholders care about.

For all of these reasons **we urge you to modify the proposed recommendation to advance public behavioral health service delivery using a Model 2 approach, by requiring that an administrative services organization serve as the vehicle to achieve service system improvements upon which we all agree.**

The draft report recognizes the need to move “through an incremental stage first, involving a non-capitated form of BHO.” Given this view, which we fully support, and the significant questions about whether Maryland has the necessary data to appropriately price a capitated MBHO rate, it seems prudent to assess system outcomes in several years with the benefit of real-life experience in implementing case rates, capitation pilots, and other performance based financing mechanisms, rather than making a unilateral decision now without these results.

We have worked collaboratively over the past 14 years with DHMH to build a system that has good access to care, has achieved enviable per capita cost containment, is one of the highest rated systems in the nation, and is supported by consumers, family members, advocates and providers alike. We now have the opportunity to improve upon this solid foundation through the implementation of performance based financing mechanisms designed to address flaws in its structure, without disruption in service to consumers. As results of financing pilots under a transformed ASO model are evaluated over the next several years, further changes can be proposed and implemented based on these results.

We believe the integration of addiction treatment and mental health service delivery under a single financing structure, the evolution of the ASO contract to incorporate performance risk, the merger of ADAA and MHA, and the implementation of a behavioral health home are transformative steps that will produce measurable results in improved service delivery and efficient use of resources to better serve the needs of the public. These are challenging steps for the Department to accomplish in just a few short years. We pledge to be as engaged in working through the nuts and bolts of the improvements we are recommending as we have been in participating in strategic discussions over the past few months.

Finally, we ask that the report include language stating that the Department will require that all Medicaid-financed behavioral health services are compliant with the 2008 Mental Health Parity and Addiction Equity Act, so that individuals are not subject to financial requirements, quantitative treatment limitations and/or non-quantitative treatment limitations that are more restrictive than those applied to somatic health care benefits in the Medicaid program.

Ultimately, the change we are collectively seeking will happen between people who are scattered in communities across this state. What you have done through this exhaustive, inclusive and respectful process is to have oriented and unified all of us in the necessary direction toward goals that will improve care for individuals and results for the public. Everyone wants to do the right thing. For these reasons, we are confident that this reform effort will produce positive results. Thank you for your leadership and for the opportunity to provide these comments.

Advocacy and Training Center
Alliance
Archway Station
Arundel Lodge
Baltimore Crisis Response
Behavioral Health Partners of Frederick
Board of Child Care
Catholic Charities Child & Family Services
Center for Children
Channel Marker
Charles County Freedom Landing
Chesapeake Voyagers

The Children's Guild
Community Behavioral Health Association of Maryland
Corsica River Mental Health Services
Crossroads Community
Eastern Shore Psychological Services
Family Services
Garrett County Lighthouse
GUIDE Program
Harford-Belair Community Mental Health Center
Helping Other People Through Empowerment Wellness and Recovery
Humanim
Key Point Health Services
Life Renewal Services
Maryland Association for Partial Hospitalization and Intensive Outpatient Programs
Maryland Association of Core Service Agencies
Maryland Association of Resources for Families and Youth
Maryland Clinical Social Work Coalition of the Greater Washington Society for Clinical Social Work
Maryland Coalition of Families for Children's Mental Health
Maryland Coalition on Mental Health and Aging
Maryland Disability Law Center
Maryland Nurses Association
Maryland Psychiatric Society
Maryland Psychological Association
Mental Health Association of Frederick County
Mental Health Association of the Lower Shore
Mental Health Association of Maryland
Mental Health Association of Maryland, Metropolitan Baltimore Branch
Mental Health Association of Maryland, Washington County Branch
Mental Health Association of Montgomery County
Mental Health Association of Prince George's County
Mental Health Association in Talbot County
Mental Health Center of Western Maryland
Montgomery County Federation of Families for Children's Mental Health
Mosaic Community Services
NAMI Maryland, National Alliance on Mental Illness – *also representing:*
 NAMI Anne Arundel County
 NAMI Carroll County
 NAMI Cecil County
 NAMI Frederick County
 NAMI Harford County
 NAMI Howard County
 NAMI Lower Shore
 NAMI Metropolitan Baltimore
 NAMI Montgomery County
 NAMI Prince George's County
 NAMI Southern Maryland
 NAMI Washington County
National Association of Social Workers, Maryland Chapter
Office of Consumer Advocates – *also representing:*

HOPE Station
Mountain Haven
Soul Haven
Self-Directed Care Program
Listening Line
Transportation Program
Omni House
On Our Own of Anne Arundel County
On Our Own of Baltimore City – *also representing:*
Hearts & Ears
On Our Own Catonsville Center
On Our Own Charles Village
On Our Own Dundalk Center
On Our Own Towson Center
One Voice Recovery Community Center
Transitional Age Youth Center
On Our Own of Calvert County
On Our Own of Carroll County
On Our Own of Cecil County
On Our Own of Frederick County
On Our Own of Maryland
On Our Own of Montgomery County
On Our Own of Prince George's County
On Our Own of St. Mary's County
Pathways
Peer Wellness & Recovery Services
People Encouraging People
Prologue
Psychotherapeutic Rehabilitation Services
Psychotherapeutic Services
Rehabilitation Systems
Southern Maryland Community Network
St. Luke's House and Threshold Services United
University of Maryland Medical Center Division of Community Psychiatry
Upper Bay Counseling and Support Services
Vesta
Way Station
WIN Team
Woodbourne Center