Integration for Medicaid-Financed Behavioral Health

Comments from Anne Arundel County Department of Health

November 8, 2012

Comments on Guiding Principles for Integration

As stated in the Recommendation submitted to Secretary Sharfstein a new system should:

- ***Provide the greatest value to Maryland consumers and individuals should be able to access the right services, at the right time (and in the right place).***

COMMENTS: The State of Maryland' richness in population diversity and geography has influenced the scope and availability of mental health and substance abuse services. The ability of jurisdictions to provide comprehensive services has been limited by many factors not the least of which has been a funding model that did not encourage and support a sustainable public and private sector partnership.

The expansion of PAC to provide a substance abuse treatment benefit (i.e. Outpatient and Opioid Maintenance Therapy) has dramatically increased accessibility.

The ability of individuals to access services at the right time and at the appropriate level of care does indeed lead to improved outcomes based on current experience with these populations.

Residential facilities (esp. III.7D and III.7) are not readily assessable across Maryland. It should be noted that III.7D frequently referred to as sub-acute detoxification should be viewed as a hospital diversion strategy.

When compared to hospital rates the III.7D level of care, which requires medical and nursing services, are provided at a significantly lower cost when compared to the cost of Emergency Departments and Hospitalization. Given this cost reduction, sub-acute detoxification should be included in the proposed financial model. At present there is a disincentive for medical institutions to contract with and financially support the substance abuse residential providers in order to divert clients from their Hospitals. In a carve-out model, that disincentive will continue and we will miss a great opportunity to reduce the cost of medical services.

Chronic medical, mental health and substance use disorders that can be safely managed at the III.7D level of care should be better supported by an integrated model.

- ***Support effective models of integrated care…should prioritize the needs of the seriously ill and should provide payment based on performance, value and outcome.***

COMMENTS: With the recommended model, mental health and substance use disorders are carved-out from medical services. By definition this will require mental health and substance abuse providers to

coordinate care and case manage with the managed care organizations. The presence of chronic illnesses should not be understated in mental health and substance use disorders.

A robust care coordination and case management structure that includes recovery support staffing offers the best opportunity to ensure that the client is clinically stabilized. To date these chronically ill, multiple diagnosed individuals who drive up the cost of all of our systems have resisted our best efforts to bend the cost curve. An integrated model is the best hope to improve outcomes.

Case management and care coordination are not funded by Medicaid. Without a sustainable funding stream, providers will be hard pressed to coordinate care and provide services to the chronically ill population who require sustained care over an extended period of time, and perhaps for their lifetime. A carve-out model will continue the fractured treatment that has frustrated the public, clients and providers for decades.

Specialized services designed to offer clients the medical, mental health and substance use disorder at the same location will ensure a "no wrong door" approach to a population that has been stigmatized beyond belief. "Shame" or "stigma" are not just a words for our population, they are a continuing life experience. For recovery to take root, an Integrated Model with Specialized Services is the best opportunity to do so.

- ***New system should include a strong role for local oversight and engagement.***

COMMENT: Local Health Departments (LHD) are the most experienced and the most effective entity to ensure that the public health focus for oversight, monitoring, continuous quality improvement and, where necessary, appropriate specialized services are offered.

Failure to provide LHDs with sufficient resources such as staff, physical space, IT infrastructure that is interoperable with state and local reporting systems and our hospital partners to ensure these functions will continue to pose significant risk to the service delivery system.

Implementation of whichever model is finally selected will be challenging to all of us and the LHD's are a visible and significant source of stability. It would be wise to maintain this stable and effective structure as the many details are developed and implemented.

Implementation concerns with the proposed "carve out" model

There are concerns about implementing a Medicaid financing carve-out model that includes both mental health and substance abuse. Some of the concerns of a carved out system include the following:

- Both the perceived and actual separation between behavioral and somatic care will be further advanced. In the last 2 years, a number of MCOs have taken on the management of people with substance use disorders when PAC coverage was expanded in 2012. This system has developed experience with and an understanding of the issues these patients face, which may now be lost.

- The need for care coordination is discussed as a disadvantage of this model and this concern is not a small issue. Care coordination even in its current state has some significant challenges that this new BH ASO would not alleviate. For example, a recent national study of "**Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries**" conducted by the University of Colorado School of Medicine and Oregon Health and Science University concludes: "Compared with individuals with private insurance, Medicaid beneficiaries were affected by more barriers to timely primary care and had higher associated emergency department utilization. Expansion of Medicaid eligibility alone may not be sufficient to improve health care access."

- One advantage cited in the report (page 20) is that having a single BH ASO would "best coordinate the transition of individuals between Medicaid and Exchange-offered qualified health plans as a single point of transition for specialty mental health services." For an individual who needs both behavioral health services and somatic care services, it seems that this model would actually have the QHP interface with both the medical MCO and the BH ASO, two points of contact rather than one.

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