

Appendix IX: Evaluation of Models Based on Criteria

Criteria		Model 1	Model 2	Model 3
(1) Best ensures delivery of the right service, in the right place, at the right time, by the right practitioner	Benefits	(1) Allows for network adequacy as long as there are specific contractual requirements; (2) Fewer transitions between entities, referrals, prior authorization requirements, etc may favor those with mild BH needs; (3) MCOs have experience handling BH needs; (4) Current system allows for patient preference to expand access through self-referral provisions; (5) Global capitation could satisfy this criterion, which is only possible under Model 1	(1) May be easier to get the "right" care if grant-funded and Medicaid services are integrated - all funds could be managed by an ASO or MBHO; (2) An ASO-version of Model 2 may result in better access without over-emphasis on controlling costs by denying services (as there wouldn't be a cap on BH dollars in an ASO)	(1) Delivery of service for SPMI may be more integrated and tailored under one plan
	Challenges	(1) Having 7 (or more, in the future) MCOs may make it difficult to standardize prior authorization requirements and provider qualifications; (2) Potential for lack of coordination between MCO/BH providers if MCOs are allowed to subcontract behavioral health to an MBHO; (3) Consensus-building may be difficult across multiple entities; (4) MCOs may not have the means/expertise to treat this population as effectively as a specialized entity	(1) A procurement that might award the work to multiple MBHOs may be more difficult to navigate for consumers/providers; (2) Potential for lack of coordination between MCOs, MBHO(s)/ASO, and BH providers	(1) Possible risk of adverse selection and incentives for MCOs to diagnose consumers with moderate needs as severe in order to disenroll; (2) Concerns about adequacy and consistency of services during recovery
(2) Best ensures positive health outcomes in behavioral health and somatic care	Benefits	(1) Potential for more comprehensive data and timely interventions due to data collection taking place within same entity	(1) Potential for richer data and measures on a population level for BH; (2) Data may be easier and quicker to access from a single entity	(1) May be easier to tailor performance targets for providers dealing with more difficult SPMI patients than it would be for a non-SPMI-specialized entity

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using measures that are timely and transparent	Challenges	(1) State may need to collect and coordinate (potentially inconsistent) data from seven (and in the future, more) MCO information systems	(1) Would require accurate and timely linkage between somatic and BH data related to each individual to monitor clinical outcomes	(1) Data may be skewed by adverse selection of patients (with MCOs potentially labeling patients as more severe to move them into the SMCE); (2) Multiple linkages may be required between two sets of somatic and BH data for patients moving between the SMCE and one of seven MCOs
(3) Best ensures preventive care, including early identification and intervention	Benefits	(1) MCOs may be incented to provide care that reduces overall cost (e.g. outpatient BH to avoid inpatient hospital), as they are responsible for the whole body care; (2) Primary care physicians may be incented to provide better care (preventive and otherwise) to mental health and substance use patients	(1) May be easier to coordinate/braid BH funding with non-MA block grants for preventive services not covered by MA	
	Challenges	(1) May be harder to track non-MA services; (2) MCOs may not have the means/expertise to do this as effectively for the population as a specialized entity	(1) Savings generated by the interventions in the BH system might reduce costs for MCOs, and those savings would not necessarily be reinvested in BH; (2) Misalignment might reduce the incentives for an MBHO/ASO to invest in interventions that create savings in the somatic system; (3) Early identification and prevention may be more difficult as consumers navigate two separate systems for somatic and BH care	(1) Patients may be less likely to seek preventive care for fear of being labeled SPMI and changing providers/MCOs; (2) There is potential for adverse incentives, i.e. SMCE may not want to prevent BH needs in order to move more people into the SMCE

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(4) Best ensures care across an individual's lifespan	Benefits	(1) Natural connection between somatic and mental health across lifespan; (2) May be easier to outreach to families where one child is identified as SPMI		If individuals remain in Model 3 (churning is eliminated) care across lifespan is achieved.
	Challenges	(1) MCOs who find it difficult to focus specifically on BH population may find it even more difficult given that BH needs tend to change over time; (2) Dual eligibles not currently being served in managed care may make it harder to coordinate care later in life; (3) FFS population would remain.	FFS population would remain.	(1) Problems with family continuity when one member has SPMI
(5) Best ensures positive consumer engagement	Benefits	(1) Established relationship with somatic providers may mean less stigma and help families seek appropriate BH services	(1) Capitated payments may allow MBHO to supplement MA funded services with grants, such as consumer-run pilots (2) Behavioral health providers have more expertise engaging consumers in self-management and harm reduction	(1) Consumer advocates could be engaged by health plans providing care to SPMI to reduce stigma (2) Requires more attention for SPMI patients (3) Patients will be more likely to access and follow up with care
	Challenges	(1) Different subcontracted MBHOs for different MCOs may mean more complicated transitions as patients switch MCOs, in terms of provider networks and other items	(1) A separate MBHO card may increase stigma. (2) It may be difficult to quantify consumer engagement across two systems of care as somatic and behavioral health interact through the lifespan.	Possibility of stigma for SPMI that may be created through the use of different health payers.

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(6) Best aligns with treatment for chronic conditions	Benefits	(1) Full integration of chronic somatic and behavioral health conditions may better align with the philosophy of the chronic disease model (the treatment of a chronic illness should involve treating the whole person).	Treating concomitant health conditions in different systems, each with certain expertise, may lead to better health outcomes.	Better integration of chronic somatic and behavioral health conditions for those with serious conditions.
	Challenges		(1) Different systems may make it difficult to coordinate care. (2) Concomitant health conditions will be treated in different systems, which may lead to poorer health outcomes as patients navigate two systems of care, potentially with multiple care coordinators from the different systems`. (3) In an MBHO version of Model 2, the MCO and the MBHO may argue who is financially responsible for specific services related to chronic conditions.	
(7) Best ensures the delivery of culturally and linguistically competent services that are evidence-based and informed by practice-based evidence	Benefits	A single somatic and behavioral health provider may increase the consistency with which CLAS/EBP are delivered to consumers.	(1) Behavioral health providers have experience implementing and monitoring CLAS/EBP services at delivered to diverse communities by various provider types; (2) A single MBHO/ASO may increase the efficiency with which providers are credentialed or form partnerships to effectively deliver these services	Providers in a specialty delivery system are likely to have long-standing experience delivering CLAS/EBP services to individuals with SPMI

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	Challenges	(1) Monitoring the consistent delivery of CLAS/EBP services across multiple MCOs may be administratively burdensome (2) Acquiring expertise in the delivery in the delivery of CLAS/EBP services takes time; MCOs new to providing these services may have a slow ramp-up thereby delaying delivery to consumers		
(8) Best ensures that the system is adaptable over time, as other payment and delivery system reforms occur, without loss in value or outcomes	Benefits	(1) This option would not require an RFP process (less administratively burdensome)	(1) Working with a single MBHO/ASO is less administratively burdensome; (2) Modifying a single contract to respond to payment and clinical delivery innovations may be less administratively burdensome	(1) A specialty delivery system may be more adaptable to emerging and innovative clinical practices as they have a smaller, more well-defined population to care for.
	Challenges	(1) Payment reform would need to occur (example: the addition of payments for behavioral health services); (2) Working with multiple MCOs could prove time-consuming and administratively burdensome (potentially more so than an RFP process)	(1) Payment reform would need to occur (example: paying for performance or capitating rates for behavioral health services); (2) As definition of primary and specialty care shift and service delivery changes, it may be difficult to re-align clinical responsibilities between the MCOs and the MBHO/ASO without repeated contract modifications or reprocurement	(1) Payment reform would need to occur (example: developing sound rates for a population that has historically required the intensive provision of services); (2) To ensure continued financial viability, rates would have to be carefully evaluated and reevaluated as the population included in the specialty group is redefined or churns
(9) Best ensures program integrity and cost - effectiveness	Benefits	(1) May be easier to coordinate care and contain costs when all care is provided by one entity	(1) Potential for easier identification of provider integrity or cost issues with one MBHO (unless, in Model 1, one MBHO is mandated that all MCOs must use); (2) Less administrative burden for DHMH monitoring of quality and compliance with contract standards.	(1) May allow for more timely examinations of claims and authorization data for population with high need

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	Challenges	(1) Need to develop a central data system that can track provider and enrollee data.	(1) May be difficult to implement disincentives to prevent ASO from continuously pre-authorizing services for recipients who no longer need mental health treatment; (2) There may be disputes over hospitalization pre-auth and payments	(1) Need to develop a central data system that can track provider and enrollee data. The system would need to collect data for individuals within the SMCE and those that remain in HealthChoice/PAC
(10) Best ensures administrative efficiencies at state, local, plan, provider, and consumer/family levels	Benefits	(1) From plan level, some administrative efficiencies may be created by having somatic and BH under one entity. (2) From family level, efficiencies may be created by only having to navigate one "system" if all members are on the same plan (whereas with other models, families where individuals have a range of BH needs may fall into different plans and providers).	(1) From state level, may have potentially less overhead in ASO or MBHO than MCO as regs/contracts are current written. (2) May be easier to track performance/utilization data for behavioral health-specific issues- such as high volume users- and quickly share across safety net systems (police dept, education). (3) May be easier to coordinate MA services with grant-funded BH services if the MBHO/ASO has a relationship to those non-MA systems.	

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	Challenges	<p>(1) Administrative efficiencies may not be met for individuals that are (or become) dual eligible; (2) From local level, may be more administratively burdensome for each MCO to deal with each of the 24 local jurisdictions on special BH projects (and vice versa).</p>	<p>(1) Providers of both somatic and behavioral health services (e.g. FQHCs) may find it complex to interface with multiple entities; (2) From state level, could require a separate RFP process to select the MBHO on top of renewing contract for MCOs (compared to Model 1, assuming MCOs contract with their own MBHO(s)); (3) From state level, could be administratively burdensome for the state as claims payment is complicated by what is considered primary care vs. behavioral health care (continued "problem ownership" of some services).</p>	<p>Administrative efficiencies may not be met for families in HealthChoice/PAC that have members in Model 3.</p>
(11) Best ensures seamless transitions as service needs change, and as program eligibility changes	Benefits	<p>(1) May provide best continuity of providers for families with a range of behavioral health needs (versus Model 3 when members of a family who have greater needs will be under a different plan.); (2) May provide best continuity of coverage (in terms of what services plans provide because individuals won't be changing plans) during recovery and major transitions.</p>	<p>(1) Greater continuity between covered BH services and non-Medicaid grant services.</p>	<p>(1) If churning is eliminated individuals with SPMI will receive continuous care over their life span.</p>

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	Challenges	(1) Availability and continuity of provider network may need to be considered; (2) Potential challenges for individuals that become dual eligibles.	(1) If one MBHO with a closed network is used, model may not allow for as much patient choice of providers as other models; (2) The separation of somatic and behavioral health services for individuals utilizing MBHO will require additional coordination.	(1) Individuals on the specialty SPMI plan may experience churning dependent on the definition of the included population (i.e., there should be a protocol to facilitate continuity and prevent relapse for an individual who is recovering from a SPMI or substance use issue).

Abbreviations:

ASO: Administrative service organization

BH: Behavioral health

CLAS/EBP: Culturally and linguistically appropriate services/evidence-based practice

FFS: Fee-for-service

MA: Medicaid

MBHO: Managed behavioral health organization (a capitated entity)

MCO: Managed care organization

PAC: Primary adult care program

SMCE: Specialty managed care entity

SPMI: Severe and persistent mental illness