2012 Behavioral Health Integration Public Stakeholder Process
Draft State, Local, and non-Medicaid Workgroup Report as of August 2012

The Workgroup Process

Executive Summary

The State, Local, and non-Medicaid Workgroup ("SLnon-MA Workgroup") met multiple times over four months to examine the role of state and local entities and non-Medicaid services as part of the Behavioral Health Integration (BHI) efforts. This report serves as the key output of the SLnon-MA Workgroup, documenting participant feedback and the underlying process.

Involvement of a diverse array of stakeholders, from somatic/mental health/substance use providers to academic institutions and government entities, allowed the SLnon-MA Workgroup to capture a variety of perspectives. Although the recommendations contained in this report may not represent every participant, several findings that can be agreed upon are:

- Prevention is a key tool for improving behavioral health and should be emphasized under any model,
- State and local organizations will need to strike a balance between process uniformity and customization to best function with limited budgetary resources, and
- Local services and non-Medicaid funding are critical to the overall behavioral health system.

The SLnon-MA Workgroup urges management and legislators to keep these points in mind when selecting and implementing a new model for behavioral health.

Charge

The State, Local, and non-Medicaid (SLnon-MA) Workgroup was created to make a recommendation on what services/financing should be left outside a "Medicaid" integrated care model to accommodate non-Medicaid-eligible populations, or non-Medicaid-eligible services. This Workgroup will also make a recommendation on the roles that state and local government should perform depending on which services/financing are left outside of the Medicaid financing model, as well as how to support and coordinate with the selected model.

The SLnon-MA Workgroup was led by Executive Sponsors Kathleen Rebbert-Franklin, Acting Director of the Alcohol and Drug Abuse Administration; and Daryl Plevy, Deputy Director at the Mental Hygiene Administration.

Stakeholder Engagement

The SLnon-MA Workgroup did not have formal membership, but interested stakeholders actively participated by attending meetings, submitting comments, and providing feedback on work products. Metrics illustrate the engagement of stakeholders in discussing the state, local, and non-Medicaid portion of the BHI reform:

- An average of 65 in-person or webinar participants attended each meeting, representing approximately 70 government offices, health programs, and advocacy groups (see page 9 for list).
- The SLnon-MA Workgroup met four times, totaling eight hours.
- In addition to feedback collected at meetings and verbal discussions with the Executive Sponsors, the SLnon-MA Workgroup received 10 submitted comments online or via email.

Overview of Meetings

- May Meeting – Reviewed SLnon-MA Workgroup charge and discussed current role of state and local entities in behavioral health services.
- June Meeting – Discussed eleven BHI criteria and which state/local functions and non-Medicaid services should be in place to best ensure criteria are met.
- July Meeting – Discussed three models and considerations for the state and local functions.
- August Meeting – Reviewed draft of SLnon-MA Workgroup report and discussed feedback.

Work Products

- Meeting Materials – PowerPoint presentations and detailed summaries capturing specific feedback.
- "As Is" List of Services – Current behavioral health services performed by state and local entities.
- Compilation of SLnon-MA Stakeholder Comments.
- Summary of All Stakeholder Recommendations by BHI Criteria

The Executive Sponsors and the Behavioral Health Integration Steering Committee would like to thank everyone who attended and/or otherwise contributed to this Workgroup's efforts.

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Important Considerations

Throughout the process, the following considerations were a common theme of discussions.

- *Incorporation of the Criteria*. The SLnon-MA Workgroup considered the most effective manner to incorporate the criteria into our evaluation process. During our June meeting, the SLnon-MA Workgroup developed specific recommendations for services necessary to best ensure each of the 11 BHI criterion is met.

- *Balance between Standardization and Customization*. Participants frequently noted that services uniform and discrete in delivery should be standardized and managed centrally by the state, whereas less straightforward services can benefit from local expertise and management. However, it will be important to ensure comparable services are available in each jurisdiction (e.g., crisis response) regardless of how they are delivered.

- *Using Current Service Levels as a Baseline.* The SLnon-MA Workgroup documented how services are currently delivered in Maryland, with recommendations on what to continue, discontinue, refine, or add accordingly. As a result, services without specific recommendations included below or in the work products may be assumed to remain as is.

- *Maintain Local Role.* Discussions at SLnon-MA Workgroup meetings demonstrated the critical role that local entities, such as Core Service Agencies (CSAs) and Jurisdiction Treatment and Prevention Coordinators (JTPC), play in facilitating behavioral health.

- *Importance of Phase 3: Specification Design.* In some instances, the SLnon-MA Workgroup was hesitant to define state and local roles without knowing which model would be chosen, or the specifications of the proposed models. The SLnon-MA Workgroup suggests additional consideration be given to their charge during the next phase of the process. For example: the role of the state in contracting between MCOs and behavioral health providers, how information/expertise can best be exchanged between state, local, and healthcare entities during the transition, and continuing to engage consumers and other stakeholders in the process.

- *Preserve Grant-Funded System.* The importance of maintaining grant-funding for services and/or individuals not covered by Medicaid was another central theme of the SLnon-MA Workgroup's discussions. A list of recommended services to be grant-funded is included on pages 6-7. Non-Medicaid funding supports Maryland's safety net for vulnerable populations and could be a key contributor to cost savings when used in conjunction with Medicaid funding (e.g., funding for prevention or data mining for high-cost users may lead to lower treatment costs over time).

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Workgroup Recommendations and Model Feedback

In line with our charge, this section contains recommendations on state and local roles as well as non-Medicaid services that should be in place regardless of the chosen model. The SLnon-MA Workgroup also gathered feedback from participants on each of the three models. Although it has not been included for simplicity's sake, each recommendation has been tied back to one of the eleven criteria (see http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx for detail on criteria and source).

The recommendations and feedback below are directly from one of the four SLnon-MA meetings or online submissions specific to our Workgroup. They have been consolidated where similar in nature.

I. State and Local Role

State

1. Realign activities and funding with the Secretary's vision by placing emphasis on prevention and screening.
2. Require insurers to have open panels of mental health providers, taking all qualified mental health providers who apply; and staff some mental health counselors in primary care offices.
3. Ensure that primary care placed mental health providers are able to participate in networks of Non-MA insurers.
4. Assist providers in obtaining additional certification, credentialing, and medical record and billing expertise. The time, commitment, and cost involved needs to be shared with the state.
5. Pilot documentation of emergency room utilization for mental health needs, collecting data to inform outcomes and rates.
6. Develop mechanisms to evaluate effectiveness of local initiatives in terms of selection criteria and outcomes in order to prioritize resources.
7. Reduce squeeze on grey zone psychiatric rehabilitation programs (PRP) recipients and enhance/build in MA-reimbursement for things like respite, child crisis, and peer services.
8. Transition oversight of residential rehabilitation centers to the state in order to free up local resources.
9. Ensure quality care structures are in place without designating exactly how these look (e.g., crisis management, jail diversion).
10. Continue to serve as final arbitrator for complaints filed at the local level.
11. Include technical assistance by the state to locals with special populations and other non-Medicaid services. Disseminate best practices and scholarly reports.
12. Use adequate rates to incentivize providers to continue to render mental health and substance use services. Rates should be reflective of true utilization from several programs, rather than just historical fee-for-service data.
13. Implement funding differentials for areas of geographic and minority disparities to address resource development and priority issues.

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State

14. Regardless of model selected, maintain administrative service organization (ASO) services at the state level.
15. Determine which services require specialists and customization versus those which can be accessed centrally. For example, transition-age youth work may be standardized at the state level: criteria, services, screening. Services like crisis response that aren't so discrete should be provided locally.
16. Standardize services that are not reimbursed by Medicaid state-wide. This will ensure all jurisdictions are getting key services (such as crisis management), and needs assessments will reveal if additional support is necessary.
17. Streamline monitoring (i.e., auditing, data request) processes and efforts that occur at the local level.
18. Improve existing processes for provider enrollment, coding, billing, etc. (e.g., ability to bill for dual mental health/substance use assessments).

Local

19. Maintain CSA and JTPC role at local level for planning, managing, contracting and providing mental health and substance use services.
20. Give local entities the authority to perform and act on needs assessments that not only look at behavioral health indicators but factors that impact on that such as poverty rates, community violence, incarceration rates, and lack of opportunities.
21. Coordinate the existing mental health providers, identifying those who accept Medicaid and those who do not.
22. Emphasize training. Maintain flexibility to train staff beyond the bare minimum.
23. Provide services and supports to younger children (ages 0-12) who may have a parent or sibling that is alcohol or drug involved to reduce their risk of subsequent use.
24. Engage consumers locally.
25. Include consumers in the training process. Use peer-to-peer support and training and empowerment as a means for workforce development.
26. Give CSAs authority to undertake pilot projects to test outcomes for investing in consumer-run (non-Medicaid) programs.
27. Manage services that are not reimbursable and do not lend themselves to data mining at the local level via contracts.

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Collaborative (or State/Local role unspecified)

28. Do not inhibit creativity and freedom for funding from non-state sources. Where state dollars are being used, use processes that are standardized and measurable to the extent possible.
29. Use a cross-cutting model for review of mental health and substance use services, such as the approach used by Consumer Quality Teams.
30. Form partnership between state and local jurisdictions for Medicaid funding because they are knowledgeable about how the consumer will best be served in the given environment.
31. Expand partnerships with institutions of higher learning from across the state for research opportunities, development of core competencies, and cross-discipline curriculum development for current students (future workforce).
32. Leverage non-government entities, who may have more efficiencies than government, offering opportunities to operate in a non-governmental framework.
33. Determine which authorities intervene at which points (regarding grievances), and how this funding stream is managed.
34. Start identifying high-cost users not linked to services (at the state level) and link them to services (at the local level). This will allow us to use resources more effectively. Perhaps implement DATALINK.
35. Promote access to supports for persons in recovery.
36. Create a "debugging" committee staffed by state and local reps to quickly remedy issues that arise during implementation.

II. Non-Medicaid Services

These services are in addition to currently funded services, as the SLnon-MA Workgroup emphasized the importance of maintaining the existing grant-funded system.

Non-Medicaid Services

37. Make funding available for intervening with any child that is in need, without having to diagnose them. This would include continued assessment and support to child care programs (CSEFEL and DECA-C).
38. Provide additional funding for training.
39. Set aside block grant funding for prevention efforts which would be based on a community needs assessment, as discussed under state roles. Include funding for GIS expansion to review interrelated variables that can assist in more targeted interventions.
40. Supplement school-based mental health services with grants for non-billable services such as support to student services, classroom management and supports, IEP meetings, teacher consultation.

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Non-Medicaid Services

41. Directly or indirectly fund behavioral health prevention activities not included in the essential benefits package. The majority of these would take a population-based approach that aims to decrease the incidence and prevalence of behavioral health disorders and their consequences.
42. Set aside dollars to create anti-stigma campaigns and perform trainings that not only educate the public about disorders, but promote good mental health.
43. Fund consumer-run pilot projects for services or populations not covered by Medicaid.
44. Expand telemedicine through grants to better integrate behavioral health and primary care.

III. Model Feedback

This feedback is intended to supplement the theory-driven analysis of each model developed by the Large BHI Workgroup. Although some participants expressed model preferences, many noted that putting the necessary processes and controls in place prior to implementation is critical regardless of which model is selected.

Model	Community Feedback
1. Service carve in	• As designed, may be best for the large portion of the population with mild behavioral health needs because the focus is not predominantly on those with moderate to severe illnesses, as in Models 2 and 3. • Strict contract requirements would need to be implemented and monitored for compliance, especially regarding care for the severely and persistently mentally ill (SPMI) population. • Work needs to be done to prepare managed care organizations (MCOs) in terms of coding, billing, and provider enrollment.
2. Service carve out (Use of BHO or ASO)	• ASO with risk carve-out favored by some commenters over behavioral health organization (BHO) with capitated rate because pent-up demand in substance use services may make it difficult to predict utilization in the early years. • May best lend itself to integrating Medicaid and non-Medicaid funding streams, so that it is seamless for consumer access. Ability to add performance risk and flexibility with reimbursement at provider level also a plus. • Although mental health and substance use systems may be easily integrated, may be more difficult to integrate and incentivize care across behavioral health and somatic care. • Data may be readily available and able to be shared across departments. • Some child and adolescent community representatives have proposed including regional and state care management entities for those with most serious illnesses as a contract condition.

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Model	Community Feedback
3. Population carve out	• Attractive because it would provide all services for SPMI, requiring less coordination. • Ideal if one BHO is at full risk for somatic care as well as behavioral health for people with SPMI or dual diagnosis; the less decisions that have to be made about populations, the more likely it may be that savings will accrue for everyone.

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Participating Organizations

- Alliance Inc
- Amerigroup
- AmeriHealth Mercy
- Arundel Lodge Inc.
- Baltimore Co. Bureau of Behavioral Health
- Baltimore Crisis Response
- Baltimore Mental Health Systems
- Baltimore Substance Abuse Systems
- Board of Professional Counselors and Therapists
- Catholic Charities
- Children's Guild
- Community Behavioral Health Association of Maryland
- Core Service Agency - Alleghany Co.
- Core Service Agency - Anne Arundel Co.
- Core Service Agency - Carroll Co.
- Core Service Agency - Cecil Co.
- Core Service Agency - Charles Co.
- Core Service Agency - Harford Co.
- Core Service Agency - Howard Co.
- Core Service Agency - Montgomery Co.
- Core Service Agency - Prince George's Co.
- Gale Recovery Inc.
- Gaudenzia Inc
- GUIDE/Linkages to Learning
- Harris Jones & Malone, LLC
- Health Department - Alleghany Co. (Addictions Program)
- Health Department – Cecil Co. (Addictions Program)
- Health Department - Dorchester Co. (Addictions Program)
- Health Department - Montgomery Co.
- Health Department - Wicomico Co. (Addictions Program)
- Health Management Consultants
- Johns Hopkins
- Maryland Addictions Directors Council
- Maryland Association of Core Service Agencies
- Maryland Coalition of Families for Children's Mental Health
- Maryland Department of Aging
- Maryland Department of Health and Mental Hygiene - Office of Eligibility
- Maryland Department of Health and Mental Hygiene - Office of Health Services
- Maryland Department of Health and Mental Hygiene - Office of Planning
- Maryland Department of Juvenile Services
- Maryland Department of Legislative Services
- Maryland Mental Hygiene Administration
- Maryland Physicians Care
- Maryland Psychiatric Society
- Medstar Health
- Mental Health Advocate
- Mental Health Association
- Mental Health Net
- Montgomery Health Federation
- Mosaic
- Mountain Manor
- National Alliance on Mental Illness in Maryland
- National Council on Alcoholism and Drug Dependence of Maryland
- On Our Own of Maryland, Inc.
- Open Society Institute
- Pathways, Inc.
- People Encouraging People, Inc
- Primary Care Coalition
- Prologue
- Public Defender
- Public Policy Partners
- Self employed
- The Children's Guild
- The Hilltop Institute
- University of Maryland - Systems Evaluation Center
- University of Maryland - Division of Child and Adolescent Psychiatry
- Upper Bay Counseling & Support Services, Inc.
- Value Options
- Walden
- Way Station, Inc.

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