

## The Workgroup Process

The Systems Linkage Workgroup was created as a part of the process of selecting a finance and integration model for Medicaid-funded behavioral healthcare in Maryland. This Workgroup was not created to make recommendations regarding the potential models. Rather, the purpose of the Workgroup was to present, discuss, and provide general feedback regarding issues that relate to the necessary linkages in systems in order to achieve true “integration.” For instance, is an electronic health record a necessary component of any integrated system? What components indicate “integrated” care versus “collaborative” care?

The Workgroup was led by an Executive Sponsor, Brian Hepburn, Director of the Mental Hygiene Administration. The Workgroup did not have formal membership; instead, all stakeholders were invited and encouraged to participate. The Workgroup met five times between May and August. The attendees of the Workgroup represented a wide array of organizations and interests (see Appendix I for details). Throughout the Workgroup process, verbal and written comments were accepted.

This report is the outcome of the Systems Linkage Workgroup process. The Executive Sponsor and the Behavioral Health Integration Steering Committee would like to thank everyone who attended and/or otherwise contributed to this Workgroup’s efforts.

## A Good and Modern System

In order to uncover what linkages should be present under any model, this Committee vetted elements that would make a Good and Modern System. Several key topics were discussed: consumer empowerment, providers, and flexibility in financing.

### *Consumer Empowerment*

Stakeholders expressed that behavioral health consumers would benefit from as high a degree of empowerment as possible. They explained that feeling empowered and independent can make treatment and recovery more effective. This includes not only the ability to self-refer, but also treatment programs that make the consumer responsible for his/her health, such as wellness and health education programs. Consumers expressed that stigma and disrespect can add to their illness, and empowerment can be a way of combating this. In fact, the ability to control one's own life in this way could be a part of the treatment itself. In addition, the most effective treatment and recovery vary from person to person, and the ability to self-refer to services would allow individuals to each get the care they need.

Stakeholders suggested consumers be involved at all levels, not just in their own treatment but on advisory and oversight boards.

### *Providers*

There were multiple statements made about providers:

1. Some primary care providers aren't sensitive to the specific needs of the behavioral health population;
2. Mental health providers sometimes won't treat consumers who have an existing substance use disorder, and vice versa;
3. Some providers want to integrate but can't afford to (adoption of electronic health records, collaboration, etc.);
4. Some providers don't read information about their patients even when its available to them;
5. Some primary care providers' offices do not feel like safe spaces to the behavioral health population (due to stigma, excess stimuli (e.g. bright lights), and others);
6. Some behavioral health consumers feel disrespected and/or patronized by primary care providers;
7. There is not enough accountability in the system for poor health outcomes, possibly due to a lack of coordination; and,
8. Somatic, mental health, and substance use providers have access to different data, use different language, and have different philosophies.

In general, stakeholders felt that providers, both primary care and behavioral health, need better training, facility improvements, incentives to integrate and align treatment, and the technological and financial support with which to do so. Some stakeholders suggested provider surveys so consumers could report on which providers provided the best care to the behavioral health population. Most stakeholders agreed that provider networks should be established to best provide continuous, comprehensive care to individuals.

### *Flexible Financing*

In line with the arguments for consumer empowerment, the Committee explained that flexible payment structures for providers are essential for the behavioral health population. The needs of individuals vary drastically from person to person, and for each person over time. Strict reimbursement procedures would likely prevent individuals from receiving the care they need in the settings they want, in a timely manner. Providers should have the flexibility to provide whatever services will be effective, and the entity should be able to reimburse these services. For instance, the two most effective, under-reimbursed services mentioned by stakeholders were peer support and physician collaboration.

In addition, care continuity is an essential component of recovery and well-being for the behavioral health population. Disruptions in access to services due to the payment system would be harmful and costly.

Further, individuals have different levels of somatic and behavioral health needs, and these needs change over time. Some individuals may benefit the most from intensive care management; others may benefit from a partnership between behavioral and physical health services providers or may be best served if these providers were fully-integrated and co-located. The system should be flexible enough to link people to the right level of coordination.

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## Systems Linkages

After discussing what elements make a Good and Modern System, the group discussed what linkages should be present under any model. It was decided that the new system should have strong links to:

DHMH - Medicaid	Corrections	
DHR	DHMH – Public Health and LHDs	Dept. of Rehabilitative Services
DHMH – IT	Dept. of Aging	HUD
CSAs	Provider associations	MDOT
MHCC	Consumer associations	VA
CMS	Family associations	Dept. of Defense
GOC	Dept. of Juvenile Services	SSA
DDA	SAMHSA	Financial Institutions
Dept. of Disability	Academic institutions	Dept. of Housing and
Judiciary	Plan/advisory boards	Community Development

In particular, the group mentioned that the link between the current ASO and the child system (i.e. education and the Department of Juvenile Services) is well-developed and strong, and any future system should maintain this strength. Additionally, many behavioral health providers currently have strong ties to consumer associations and housing entities, and these should be maintained as well. Stakeholders mentioned the necessity of a single, up-to-date electronic health record, easily accessible by all entities.

## Potential Models

After discussing the elements of a Good and Modern System, as well as the necessary linkages within that system, the Committee discussed each of the three models. There was a general sense of unease in the group regarding current practices of MCOs and BHOs, and a good portion of the dialog around the models included fears pertaining to the current system and what improvements would need to be made to maximize the effectiveness of these models.

Where relevant, these fears about the current system will be mentioned. However, the purpose of this process was to vet the models in their purest form and discuss strengths and challenges of Maryland moving to such a model. As a result, these points should not be viewed as reasons not to pursue any particular model, but as issues that require specific attention once a model has been selected and the specifications are being developed.

### *Model 1*

The Committee acknowledged that a single entity responsible for the total health care of all of their beneficiaries across the lifespan, no matter their health care needs, was an ideal system. However, the group expressed the most concern regarding Model 1 as a potential model. This was due to experience and impressions of the current MCO system. The biggest worries about MCOs providing BH services pertained to data collection, expertise, and culture.

The Committee pointed out that having seven different MCOs means seven different sets of data, with no true linkage between the sets. Getting timely and comprehensive data was stated as a problem regarding the current MCOs. The Committee noted that, if Model 1 was pursued, there would need to be a better alignment of data across MCOs as well as increased transparency and timeliness.

The Committee expressed concern regarding the uniqueness of the behavioral health population. The worry was that an entity responsible for the total health care of all its beneficiaries would not have the means or expertise to take into account the special needs of the behavioral health population. For instance, behavioral health patients tend to require more time with a physician than the general population, due to barriers such as transportation. An entity that is neither familiar with nor focused on the behavioral health population may not design its reimbursement structure for physicians in such a way that is beneficial to this population or sustainable for behavioral health providers. In other words, cultural competence was a concern under this model.

Another concern was regarding the current culture of treatment under MCOs. The Committee stated that MCOs currently focus on the treatment of illness and recurrence prevention, which is certainly a crucial component of health care, particularly on the somatic side. However, behavioral health requires a significant degree of prevention, early identification, and recovery support. In addition, treating a behavioral health population requires physician collaboration, care management, and data sharing, elements that may be unfamiliar to an entity that has historically served a population's somatic needs. The Committee expressed concern that a single entity responsible for both the somatic and behavioral health needs of a population would not serve the population as well as a specialized entity.

The group was concerned about losing the strengths of the current system if Model 1 was pursued. In particular, the current public mental health system (PMHS) has strong, effective ties to the child system

(e.g. education, Department of Juvenile Services). It also has strong community ties to providers. These linkages would need to be maintained through MCOs if Model 1 is recommended.

## *Model 2*

This Committee expressed overwhelming support for Model 2, as long as the contract with the entity involved performance-risk instead of insurance-risk (i.e. an ASO model instead of a BHO model). The group said this would retain the strengths of the current system and add additional cost containment strategies. Some supported Model 2 because it was closest to the current system, and they were concerned about how a significant change could affect an already vulnerable population. Committee Members also noted the possible benefits of a system that is driven by behavioral health providers for the behavioral health population. Other than poor provider network information, which was a complaint for all current systems, this group did not express apprehension about this option.

The Committee pointed out that under this Model, just as under the rest, its success would depend on strong, effective specifications. For instance, the link between the ASO/BHO and the MCOs would need to be timely and accurate. This would allow all physicians access to data on their whole patient, not just either his/her somatic or behavioral health history, as well as allow for quality control. Cost allocation would need to be established between the ASO/BHO and the MCOs such that savings on the somatic side due to behavioral health care would be seen by the behavioral health entity. Providers would need to be encouraged to work together, perhaps through the reimbursement of collaborative meetings, co-location, technology, or other mechanisms. Committee members also noted that behavioral health often displays as something else early on, and that diagnoses and where someone is in their recovery process can vary significantly. The criteria to receive services under the specialty behavioral health entity should be selected carefully, and should be flexible.

## *Model 3*

The Committee expressed concern for this model on the issue of churn. Recovery is a primary focus of behavioral health treatment, and sustained access to behavioral health services is one of the ways individuals remain healthy. If a person was disqualified from participation in the specialty BHO once they recovered, it would make relapse more likely and could effectively decrease the health of the population and increase costs. An individual should be able to remain in the specialty BHO for a certain amount of time after recovery, or some other action should be taken to prevent constant churn between MCOs and the specialty BHO.

There was some concern about prevention and early identification with this model. A model that focuses on a high-need population, by definition, does not focus on the population of people who are at-risk. The group was concerned that at-risk individuals, in particular at-risk youth, would not receive the preventive care they need under this model. They also pointed out that children and adults present severe behavioral health needs differently, and the specifications of this model would need to be mindful of that.

Some of the Committee expressed concern that this model may create stigma for patients with severe behavioral health needs. Being served by a separate entity even for somatic care, having a different insurance card, seeing different doctors, may be stigmatizing for a highly vulnerable group. Other Committee members argued this point, saying the entity providing health care needs isn't often an

obvious one, and people are more concerned about accessing effective, reliable treatment in a safe environment than who is responsible for the payment.

The Committee pointed out that this model would mean somatic and behavioral health care would be provided by the same entity, so care continuity and coordination, as well as data collection and quality management, may be simplified. However, family continuity may be disrupted as families with one or more members with severe behavioral health needs would be served by different entities. Committee Members also noted the possible benefits of a system that is driven by behavioral health providers for those with severe behavioral health needs. Like with Model 2, it was also noted that behavioral health often displays as something else early on, and that diagnoses and where someone is in their recovery process can vary significantly. The criteria to receive services under the specialty behavioral health entity should be selected carefully, and should be flexible.

The Committee wondered if having all high-cost behavioral health patients served by one entity would be a problem from a budget standpoint. As an expensive program, as well as a program serving people very different from the general population, would this program survive budget cuts? Some Committee members said this model would be the best way to demonstrate cost-savings for this population and would, in fact, be the safest place for the care of this population.

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## Attending Organizations/Affiliations

- Affiliated Sante Group
- Alliance, Inc.
- American Psychiatric Association
- AmeriGroup
- Anne Arundel County - Mental Health Agency
- Anne E. Casey Foundation
- Arundel Lodge
- Baltimore Community Resource Center
- Baltimore County - Bureau of Behavioral Health
- Baltimore Crisis Response, Inc.
- Baltimore Mental Health Systems
- Baltimore Substance Abuse Systems
- Board of Professional Counselors and Therapists
- Catholic Charities
- CBH Health
- Charles County - Core Service Agency
- Chase Brexton Health Services
- Consumer advocates
- Coventry Health Care of Delaware
- Delmarva Foundation
- Department of Budget and Management
- Department of Disability
- Department of Health and Mental Hygiene - Alcohol and Drug Administration
- Department of Health and Mental Hygiene - Mental Hygiene Administration
- Department of Health and Mental Hygiene - Money Follows the Person
- Family Services, Inc
- Harford County - Core Service Agency
- Health Management Consultants
- Howard County Health Department
- JAI Medical Systems
- Johns Hopkins
- Johns Hopkins Bayview Community Psychiatry
- Keystone Service System
- LifeBridge Health
- Maryland Association of Core Service Agencies
- Maryland Addictions Directors Council
- Maryland Disability Law Center
- Maryland Hospital Association
- Maryland Physicians Care
- Maryland Psychiatric Society
- MedStar Health
- Mental Health Association of Maryland
- Montgomery County Core Service Agency
- Montgomery County Department of Health and Human Services - Behavioral Health & Crisis Services
- Montgomery County Health and Human Services
- Mosaic Community Services
- Mountain Manor
- Mt. Washington Pediatric Hospital
- National Alliance on Mental Illness in Maryland
- On Our Own of Maryland
- Open Society Institute
- People Encouraging People
- Prologue
- Public Defender's Office
- Public Policy Partners
- Riverside Health
- Springfield Hospital Center
- The Children's Guild
- The Hilltop Institute
- The Institute for Innovation & Implementation
- Total Health Care, Inc
- University of Maryland
- University of Maryland Carey Law School
- University of Maryland System Evaluation Center
- University of Maryland, Baltimore County
- Value Options
- Way Station, Inc.