General Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: I am a current Practice Change Fellow whose project in on integrating somatic and psychiatric care in the elderly. I hope your committee includes frontline general medicine clinicians. Pediatricians also should be involved as many adolescents have depression/substance abuse issues. There needs to be community health workers/case managers to follow-up with these patients between office visits.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: The model should best ensure maximizing of self-efficacy and ongoing health education across the life span.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: This is about Model #3 of the three proposed potential models. As Mr. Milligan stated repeatedly at the meeting earlier this week, the Department did not receive comments on that model in the first official public comment period. Speaking on behalf of NCADD-Maryland, the organization did not make any comments because it only has questions. So here they are:
- Are there examples in other states where this kind of model has had successful health outcomes?

DHMH Response: This is a relatively new model. It is being implemented in Maricopa Arizona (Phoenix area) and in New York City. It shows promise for providing comprehensive care to a high risk targeted population. Although we know of no long term projects such as this with SPMI populations, the PACE program which is a nationwide program that provides comprehensive care to adults who meet nursing home level of care has been a highly successful program.

- Are there any examples of high-risk specialty MCOs having successful outcomes in health and having been affordable?

DHMH Response: The State would have to develop rate setting to ensure that the rates are robust enough to serve the population. The PACE program combines Medicare and Medicaid

funding. These programs have been successful in serving high risk populations and remaining in business.

- What is the level of consumer choice envisioned in this model? Will folks with specific diagnoses automatically be put into this specialty BHO? Will folks be able to opt in if they have less serious diagnoses but want the specialty?

DHMH Response: Stakeholders could have input into these issues. With the Rare and Expensive Case Management program, folks do need to meet the diagnostic criteria to enter the program. However, if they choose, they can instead enroll with one of the seven MCOs. Most individuals select REM, but there are a significant number who choose to remain in fee-for-service.

- When some one's behavioral health problems are successfully addressed and the person's health improves, will the person need to change MCOs and possibly providers? Will they be able to re-entry the specialty BHO if they relapse or have some reoccurence of their dianosis?

DHMH Response: It was our assumption, that individuals with SPMI or chronic SUD could remain in the specialty BHO/MCO even if their health improved. The goal is to stabilize and improve health so it would not make sense to force disenrollment once that occurs. On the other hand, stakeholders can comment on whether individuals can choose to leave the specialty BHO/MCO and enroll in one of the other general MCOs.

- Will the "specialty" of this BHO be defined by additional case management benefits and/or a broader array of wrap-around services?

DHMH Response: It would make sense that the specialty BHO/MCO would be given additional resources such as those necessary to implement a chronic health home. The specialty BHO/MCO would have the full array of all current services. Stakeholders can comment on whether there are additional wrap-around services which will result in better outcomes for this population.

It is difficult to have any idea if this model would be appropriate without some of these, and possibly other questions from smarter people being answered. Where will details about this model be discussed so stakeholders can provide informed feedback?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: Because of the fee-for-service nature of the Public Mental Health System that was implemented in 1997, there is a good sense of the probable increase in the demand for and cost of services as the population eligible for Medical Assistance increases. The grant based system that has been used for reimbursement for substance use services has not provided that same level of demand based data. How would the need for and cost of substance use services for the MA population be determined to establish the "protected" premium in model 1 or for the behavorial health service system in model 2? Is it not possible and perhaps likely that the premium for substance use services will be understated if it is based on historical MA data and that resources that go into the system as a result of the better known demand for mental health services will have to be used to pay for substance use services?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: There has been a consistent reference to legislative changes being made if they are necessary. Given that the provisions of the Specialty Mental Health System are in legislation, regualtion, and the 1115 waiver document, and given that it has been made clear that the current system will not continue, why would there be any question of whether legislative as well as regulatory and waiver application changes are necessary?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Services need to be covered to best serve the patients. One fear with a model other than FFS is that services that should be reimbursed are not for some reason or another. But we support a model that leverages Medicaid money as much as possible and that covers all levels of care.

Further, in an outcomes-based payment system, the rates must reflect the expenses providers incur that are not directly related to treatment, but are nonetheless necessary and make treatment possible. If these aren't factored into the model, smaller providers will be hurt significantly.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☒ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Following up from presentations at the OOOMD summer conference last week, we would like you to find ways to maintain the qualities of the current public mental health system. Maryland has one of the very best PMHS in the US, partly due to the mental health focus of our current Medicaid carve-out for specialty mental health.

It is of considerable concern to mental health consumers that an integrated system will loose some of the strengths of our current system. Patient focus with choice of providers is difficult to maintain in a closed panel managed care organization. Must allow open participation for all providres both public and private.

As a consumer wellness and recovery center we are very concerned that our time funding for essential peer support services and consumer activities will be difficult to fund and maintain. Study over the past year has indicated that fee for service for peer support will not cover much of the current consumer activities in MD. If the summer conference is as valuable as we believe, how will funding be protected over the longer term? How will services to non-Medicaid Marylanders with mental health needs be maintained?

How will mental health advocacy activities be a focus in a new world where all services are integrated? Maryland's advocacy organizations are really strong and need to continue.

Integration of mental health, behavioral health S.A., and somatic health is critical to improving consumer health status. This must be accomplished without taking away the advantages of the current carve-out.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Criteria for an Ideal System:

- Clinical model should dictate financial model
- True continuum of care across lifespan; provide more person centered services without a fear of cost
- Consumers having a choice of care(consumer taking more responsibility in their care); should be protected and not provider's choice
- Should have flexibility in financing for the provider, not all tied to FFS/ Good outcomes are rewarded
- Funds follow consumer which gives them flexible funding; more choices
- Focus on vulnerable population that need their care integrated
- Shared risk
- Behavioral health needs to be included in the electronic health record system so the consumer's information can follow him easily
- Funds go to clinical services and not the administration
- Expand continuum of care; customize consumer care to fit each individual
- Alternative medicine
- Flexibility of services
- Continuum of care across systems (DJS, DHR, MSDE)

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: We joins the mental health coalition in urging that a version of model number 2 be adopted -- retain current ASO system but build in performance and financial risk sharing at ASO level and provider level, and add health home services as an additional MA program. We believe that this model (I will call it "2B") would best support translating all ten integration principles into practice. We also believe that a health home fulfills all ten principles. We believe that the current public mental health system in Maryland is very good, and that carve-in models in other states have not been as effective in caring for individuals with SMI and SED. The modification of 2B adds two very important enhancements to the MD system: i) health home model such as Missouri's will improve integration between behavioral health and primary care; and ii) performance and financial risk sharing at ASO level and provider levels will improve cost containment.

We believe that model 2b will be more effective than model 1 in all aspects, including improvement of physical health of consumers because the major barriers to physical health relate to the behavioral health conditions, and model 2b will best address those behavioral health conditions. And, as noted above, model 2b included this innovative behavioral health home program that also will directly impact the physical health outcomes

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: In defense of a carve-out -- See summary of CBH response to the Md Psychiatric Society's letter promoting a carve-in: "CBH Response to MPS Re. Carve-Out.pdf"

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: 9/3/2012

Contact Information:

Related Workgroup(s) (if applicable):

- [x] Systems Linkage
- [ ] State/Local and Non-Medicaid
- [ ] Evaluation and Data
- [ ] Chronic Health Home

Comment: This is about the difficulties encountered by perspective nursing home residents who still live in the community and who need to apply for Medical Assistance for Long Term Care.

In Maryland, it is not possible to apply for Medical Assistance for Long Term Care until one is in a nursing home. It would be to people's best interest, obviously, if they could apply for Medical Assistance for Long Term Care when they are still in the community so they know their financial obligation to the nursing home. In my experience as a social worker, I have seen people enter a nursing home when no one is available to care for them at home. If they are married, their spouse is unaware of how much of their income and assets they will get to keep. Nursing homes can ask for all of their liquid assets to "spend down" before they apply for Medical Assistance to find out later that the spouse could have kept half the assets. Medical Assistance for Long Term Care has different eligibility requirements than Medical Assistance for people in the community so applying for Community Medical Assistance does not help the perspective nursing home resident. It should be possible to apply before one goes into a nursing home.

Systems Linkage Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☒ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: In response to your request for written comments to better inform the activities of the Systems Linkage Options Workgroup, we are submitting the document entitled, The Ideal Substance Use Disorder Treatment System in Maryland. The document was developed, refined and updated by substance use disorder treatment providers throughout the state to clearly outline what should be included in an ideal system for treatment of substance use disorders in Maryland.
Please use this document as you examine system linkage options and begin developing an integrated and responsive behavioral health system. If you have any questions, please contact us.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☒ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Following up from presentations at the OOOMD summer conference last week, we would like you to find ways to maintain the qualities of the current public mental health system. Maryland has one of the very best PMHS in the US, partly due to the mental health focus of our current Medicaid carve-out for specialty mental health.

It is of considerable concern to mental health consumers that an integrated system will loose some of the strengths of our current system. Patient focus with choice of providers is difficult to maintain in a closed panel managed care organization. Must allow open participation for all providres both public and private.

As a consumer wellness and recovery center we are very concerned that our time funding for essential peer support services and consumer activities will be difficult to fund and maintain. Study over the past year has indicated that fee for service for peer support will not cover much of the current consumer activities in MD. If the summer conference is as valuable as we believe, how will funding be protected over the longer term? How will services to non-Medicaid Marylanders with mental health needs be maintained?

How will mental health advocacy activities be a focus in a new world where all services are integrated? Maryland's advocacy organizations are really strong and need to continue.

Integration of mental health, behavioral health S.A., and somatic health is critical to improving consumer health status. This must be accomplished without taking away the advantages of the current carve-out.

State/Local Role and Non-Medicaid Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: I raised this question at the last large group meeting and did not get a response to it. There is currently a clear distinction between those services funded through Medical Assistance and state only funded services. The planning for the financing, managing and monitoring of these services is one major charge of this workgroup. However, there are currently serveral mental health services in the Medical Assistance benefit that are unlikely to be included in the baseline benefit defined by the Exchange. These services are certainly not included in the plans from which the Exchange is charged with making its selection. Will that mean that these services will not be part of the Medical Assistance benefit? Will Maryland forego the federal match for these services and covert them to State funded services? I am not sure that I understand how is it possible for this workgroup to carry out its charge if the question of how (and perhaps if) these services are to be funded after the implementation of whatever model is adopted really remains undefined?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: Because of the fee-for-service nature of the Public Mental Health System that was implemented in 1997, there is a good sense of the probable increase in demand for and cost of services as the population eligible for Medical Assistance increases. The grant based system that has been used for reimbursement for substance use services has not provided that same level of demand based data. How would the need for and cost of substance use services for the MA population be determined to establish the "protected" premium in model 1 or the behavioral health service system in model 2? Is it not possible and perhaps likely that the premium for substance use services will be understated if it is based on historical MA data and that resources that go into the system as a result of the better known demand for mental health services will have to be used to pay for substance use services?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: I think it is important to clarify the scope of the state/local role and non-Medicaid services workgroup, and differentiate between:

- Services not funded by Medicaid
- Services for non-Medicaid-eligible individuals
- Functions that should occur on the state and local level and the role of local behavioral health authorities

The merging of the state/local role workgroup and the non-Medicaid services workgroup suggests -- erroneously -- that the local role is primarly focused on non-Medicaid services. In fact, the state's core service agencies are very involved in a diverse range of activities over and above their funding of non-Medicaid services. They include many oversight and management functions relating to Medicaid-funded services. In addition, core service agencies have a history of creating new programs through innovation and serving as system-level partners with local education, social service, juvenile justice and criminal justice systems, LMBs, health departments, police, etc. If the workgroup scope includes a focus on the role of Maryland's local behavioral health authorities, then now or once the financing model is selected, Maryland should look to the experience of other states that have implemented a similar financial model, and examine those which have established effective local behavioral health authorities.

Finally, a consideration of non-Medicaid services would be best done in a manner that includes both Medicaid-eligible and non-Medicaid-eligible individuals, since people move between these categories, yet their need for housing and other non-Medicaid-funded services remains constant.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☒ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Following up from presentations at the OOOMD summer conference last week, we would like you to find ways to maintain the qualities of the current public mental health system. Maryland has one of the very best PMHS in the US, partly due to the mental health focus of our current Medicaid carve-out for specialty mental health.

It is of considerable concern to mental health consumers that an integrated system will loose some of the strengths of our current system. Patient focus with choice of providers is difficult to maintain in a closed panel managed care organization. Must allow open participation for all providres both public and private.

As a consumer wellness and recovery center we are very concerned that our time funding for essential peer support services and consumer activities will be difficult to fund and maintain. Study over the past year has indicated that fee for service for peer support will not cover much of the current consumer activities in MD. If the summer conference is as valuable as we believe, how will funding be protected over the longer term? How will services to non-Medicaid Marylanders with mental health needs be maintained?

How will mental health advocacy activities be a focus in a new world where all services are integrated? Maryland's advocacy organizations are really strong and need to continue.

Integration of mental health, behavioral health S.A., and somatic health is critical to improving consumer health status. This must be accomplished without taking away the advantages of the current carve-out.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Here are some of my thoughts for the local and state, non-Medicaid workgroup

First, a couple of key notes on my thoughts --

1) I am assuming that the ACA stands in some form and that the primary source of public funding for behavioral health treatment will not be through a Behavioral Health Administration or grant-funding, but rather rest with MCOs and QHPs in the HBE.

2) I am assuming that the Essential Benefits package selected in MD for those purchasing insurance through the HBE and for those entitled to Medicaid will primarily cover acute inpatient hospitalizations and ambulatory prevention and treatment services provided in healthcare facilities. It would not include residential services currently available as part of the ASAM system of care used in MD and it would not cover most, if not all, recovery support services (exclusive, perhaps, of case management).

3) I am assuming that the specialty mental health carve-out will no longer exist as currently structured, particularly with respect to the ASO and the functions and responsibilities that rest within DHMH as a result.

A few thoughts --

1) The primary over-arching approach needs to come from public health and not a primary treatment approach. In my experience, the latter has been the main framework within which MHA and ADAA have operated until fairly recently. There is certainly an intersection between public health and medical/behavioral health treatment, but it's not 100%. A public health approach would imply that local and state entities not typically directly provide behavioral health treatment but have indirect relationships to these services.

2) It is critical to note that although there is overlap between the two large populations of those with or at-risk for mental health disorders and those with or at-risk for substance use disorders, it is not 100%. In fact, national and Maryland state-specific data indicate that the overlap is between 30 to 40%. Other states and localities (NY, CT, and Philadelphia) that have integrated behavioral health systems have recognized this and have maintained separate units or offices for substance abuse and mental health within their overarching behavioral health departments or administrations. These offices work extremely closely together but also are able to effectively address issues and areas unique to each population. One way to be systematic about this is to look at the epidemiology of the populations, including data that has been presented in the Data and Evaluation Workgroup.

3) Another note on populations. It is important also to be specific about the populations of which we are speaking. On the mental health side, the majority of those who are served through the public mental health system have a severe, persistent mental illness while those with mild to moderate mental illness are currently primarily served in primary care or through private providers, supported by MCOs (in the case of primary care), commercial insurance, or out-of-pocket payments. On the substance abuse side, there is not as clear a delineation between severity categories of the population or between a publicly-funded specialty system, primary care, and privately-funded providers. Until recently, the vast majority of treatment services have been through a grant-funded, publicly-supported specialty treatment system. Only within the last few years has there been movement within primary care and other non-specialty settings to screen and identify not only individuals who may have severe substance use disorders but also those with hazardous levels of use that need intervention as well. Previously, many of the latter individuals found their way to specialty services through the legal system (e.g. DUI/DWI). Thus, the population on the substance abuse side likely is more heterogeneous. Considering this, it may be helpful to clearly delineate preferred settings of care for broad categories of severity so that a common understanding can be reached.

4) I harp on populations because public health is about populations. Considering this, key functions for local and state entities can be drawn from the National Association for County and City Health Officials (NACCHO's) core public health functions and adapted. Some suggestion are found below.

a. Conduct and/or oversee local and state-wide, respectively, monitoring efforts as it pertains to the health status of populations affected by behavioral health conditions.

b. Develop policies and plans based on local and state-wide, respectively, monitoring efforts and the latest scientific knowledge of behavioral health conditions.
c. Conduct and promote education and outreach to public, healthcare professionals, advocates, legislators, etc on all issues pertaining to behavioral health (including dissemination of reports generated by the local and state entities)
d. Have strong regulatory voices on issues related to behavioral health at the local and state level, respectively
e. Participate with other local and state entities, respectively, on key initiatives, policy setting, etc to ensure inclusion and promote understanding of behavioral health (eg emergency preparedness, communicable disease, chronic diseases, workforce development, criminal justice, Medicaid, Temporary Cash Assistance, child welfare, etc)
f. Directly or indirectly fund behavioral health treatment services not included in Essential Benefits package, including residential services.
g. 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.
h. Contribute to and coordinate funding with other local and state agencies, respectively, for recovery support services that are critical to sustaining recovery and decreasing the prevalence of adverse consequences from behavioral health disorders.
i. Work in conjunction with academic health centers and universities to evaluate key initiatives and policies.
j. Serve as a resource for workforce development in behavioral health.

My one additional general comment is on the 11 principles. While I completely agree and understand that the workgroups need to consider them in doing their work, in looking at them again, it seems to me that a couple of them speak more the implementation of a model and not necessarily are directly related to selecting a particular model.

For example, doesn't the principle "Best ensures the delivery of culturally and linguistically appropriate (CLAS) and competent services that are evidence-based and informed by practice-based evidence" apply to all three models and is something that would be important to ensure in implementing a model?"

Maybe that's the only one but as I was going through them I had a hard time figuring out how to really look at the three models in relationship to that principle. Maybe there could be an implementation principle list started?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization: Stone Run Family Medicine

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: To best ensure right service, time, place, practitioner, what functions should be done…
At a STATE level, have funding available to place more mental health counselors in primary care offices. Also require insurers to have open panels of mental health providers, taking all mental health providers who apply.
At a LOCAL level, coordinate the existing mental health providers, identifying those who take MA, as well as Non-MA
Outside of MEDICAID, ensure that primary care placed mental health providers are able to participate in networks of Non-MA insurers.

To best ensure Positive, measurable outcomes should be done…
At a STATE level, through pilot or other avenues, have documentation evaluating items such as ER utilization for mental health needs,

To best ensure preventive care, what functions should be done…
I'm not sure how to divide this on a STATE, LOCAL level, but what I would consider mental health preventive care would fall into the realm of increased education, decreased availability of agents of substance abuse

To best ensure care across an individual's lifespan, what functions should be done…

Establish a PCMH for patient’s who have mental health disease

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Behavioral Health system functions most effectively performed locally

There is a necessary role for local behavioral health agencies related to:

- Providing public access to: information and referral, assistance with service needs, crisis services, education about behavioral health, and access to care (system navigation)
- Conducting community needs assessment and planning to address individual and community needs through work with other local system-level and governmental partners (i.e., housing, police, courts, schools, social services, etc.,)
- Developing innovation programs and promoting best practices
- Performing system oversight functions (i.e. complaint resolution, quality monitoring, network development)
- Monitoring and managing at the system level utilization of highly intensive/costly treatment services (i.e. state hospital beds, acute inpatient, Residential Rehabilitation Programs, Capitation Programs, emergency rooms, etc.)
- Promoting and supporting the development of housing opportunities
- Coordinating behavioral health disaster planning and response
- Managing of non-Medicaid-funded service delivery, as well as select components of Medicaid-funded service delivery (those where local authorities are well-positioned to manage)

- In collaboration with local health departments, promoting behavioral health wellness and prevention

Evaluation and Data Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: A number of data requests were put forward at Tuesday's BHI State/Local/NonMedicaid Workgroup meeting. Summarized below are data elements that the Mental Health Association recommends as helpful in informing the work of this committee:

- Can we get a county by county analysis of the non Medicaid funded services that are offered in mental health and addictions (variability of offered services is significant from county to county, and it would be helpful to see a matrix which itemizes the services provided in both systems at the local level)
- Can we get an itemization of how these services are funded in each jurisdiction (by local government, government or private sector grants, or other means) and specifically how much funding is provided by local government in each jurisdiction (mental health core service agencies have already collected some of this information in the past and may be able to quickly update or refine existing documents)
- If we are to be examining and recommending restructuring of the local government entities that oversee behavioral health delivery, can DHMH provide:
  - An environmental scan of how local government is organized to manage these services in other states; analysis of these systems and information about effective or promising initiatives that are underway in other states
  - A summary and analysis of possible structural options for Maryland to consider that stakeholders can review and respond to

It was unclear from the discussion whether the purview of the workgroup is broad (are we examining non-Medicaid funded services needed within and outside of the Medicaid arena and how these should be organized at the state/local level) or narrow (considering the organization and interface of non Medicaid services that are needed by Medicaid recipients only, without getting into a discussion of complete restructuring of state/local roles at this time)? This needs to be clarified prior to the June meeting.

Additionally since this is a time abbreviated process with just a few meetings over the summer, rather than brainstorming on the ideal system and needed services (whether for Medicaid only or all behavioral health service recipients), if the local services currently offered are shared in advance of the next meeting as requested above, along with model system of care documents for children, adults and older adults, we can have an efficient and inclusive discussion at our next workgroup meeting with a goal of clarifying those non Medicaid services needs that are most important to stakeholders. If it would be helpful for stakeholders to suggest model system of care documents prior to the next meeting, we can certainly do this and get back to you with unified recommendations from the MH Coalition on this point.

Finally, stakeholders recognize the tremendous amount of pressure this process is placing upon a very small core staff within DHMH. We view this exercise as a team effort and are ready and willing to assist in the collection of information or other functions that would be helpful in relieving some of this burden. Please do not hesitate to call upon us. The Maryland Mental Health Coalition is meeting every Friday morning by conference call to coordinate our efforts and I can relay any messages along these lines to our network as needed.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: I suggest that in presenting the data on use of inpatient care, that an additional line be added wherever inpatient data is presented with a break out of that portion of the inpatient care that is represented by a re-admission within 30 days of a prior inpatient admission. This is a very important metric that is currently used in the field and will be useful in informing the decisions about implementation of the model(s) of care we plan to use. Thank you.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: I think that there are three pieces of data which are missing from this grid:1. Dually Eligible Individuals should be separately identified (many individuals with mental helath disabilities and an employment history are dually eligible) ; 2. Most frequented place of service should be identified by provide type and 3. Potential underestimate of substance use clients should somehow be established.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: The current ASO system provides the Mental Hygiene Administration with a wealth of timely and complete data. MHA has access to eligibility, provider, authorization, claims and Outcomes Meausrement System data sets. Because the data are embedded in the financing system, data are complete and timely within the 12 month Medical Assistance timely filing limits. Individual consumer and provider information can be related across these data sets. Because many State funded services were also converted from a grants/contractual system into a fee-for-service system, reimbursement for those services became dependent upon the provision of and billing for them. That leads to at least two questions. 1. Will the behavioral health system provide reimbursement for State-funded services through its authorization and claims system since that is occurring today. The alternative, of course, is to return to a grant or contract service that will rely on some external reporting system that will have to be written, tested and implemented presumably by the time that the financinig system is implemented. (I am assuming that since such services were taken off the discussion table, that the latter situation will be the one under which the system will operate-editorially, I feel this is a step back) 2. Will the same or very similar data be available across the behavioral health system AT LEAST for Medical Assistance funded services subseqent to the integration of services? It would seem essential to have such data and to be able to relate new data to historical data in order to evaluate the performance of the system, to implement and operate pay for performance programs, and, in the case of a protected carve out, to assure that the Medical Loss Ratio for behvaioral health is maintained at requried levels. While I have no personal experience with

the MCOs reporting of service encounters, reports that I have heard about maintaining the same level of data integrity and completeness may make it challenging.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: In his comments regarding the Evaluation Data at the May 1 meeting, Mr. Milligan referred only to claims based outcomes. Most of the national outcome measures as defined for behavioral health by the Substance Abuse Mental Health Services Administration (SAMHSA) are community focused and, in fact, not claims based. Both MHA and ADAA currently have systems that collect some NOMS data. Losing access to these data would have a serious negative effect on the evaluation of any behavioral health system that emerges, would make pay for performance and quality improvement initiatives and perhaps accreditation more challenging, and would likely put any future block grant funding in jeopardy as SAMHSA will likely continue to require that NOMS be collected and reported as part of block grant requirements. Additionally, it would seem that data collected through these mechanisms external to claims would be helpful in the process of the selection of a financial model.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: The data that are being examined for model selection have been limited to Medical Assistance claims and encounter data. There are other data sources that have data that is potentially very useful and actionable. The Mental Hygiene Administration does two annual consumer surverys, one for children and one for adults. While there may be a slight selection bias in which consumers elect to participate, the initial sample is a random one stratified only by region and the demographics of the respondents correspond closely to those of the PMHS participants. Questions are included about whether the consumer has a PCP (90% of adult respondents and 98% of child/caregiver respondents answered positively). There are additional questions regarding accessing the somatic health care system as well as questions regarding the need for, access to, and satisfaction with substance use services. Should not such data be relevant to and included in the decision making process? I can certainly provide assistance in obtaining the data and even completing some finer level analysis if that is warranted.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: Provide some opportunities for small business, increase competition in Health data sector. If ASO will still be used after the integration, I suggest at least part of Data reporting system should not be included in one whole RFP, in this way, some samll business companies will have opportunity to bid, because several large ASOs which I have been working with or heard comments from county or providers were tremendously low efficiency, some reports could not deliver till the end of the contract, some small projects could spend 2 or 3 years even more to complete with 10 more people, which I can finish it just in 6 months by only myself, and also State should consider sharing some resource to County level or even provider level. My Medicaid Claim EOP reporting system may give you some idea. If you are interested in it, please go to http://www.hhtdata.com/default.html, all projects were finished by myself.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: I am following the integration initiative with interest, but also with a little alarm when it comes to data.

I understand that the Federal NOMS system requires entry of data. However, the SMART system used by the ADAA has not been even slightly user-friendly, requires duplicate entry of data, and is simply not capable of meeting agency needs as an E.H.R. The recent initiative to consider upgrading SMART promises little - the reality is that multi-service agencies require customized E.H.R.'s that are capable of handling a wide swathe of information that will never be addressed by a "one-size-fits-all" SMART look-alike. With this in mind, I respectfully ask that, however the integration ends up being designed, the following principles be considered.

1. Agencies should be able to use their own EHR's to report data and should not be forced to duplicate data entry as is required under the current SMART system. The SMART system is notoriously difficult to use, and has very poor validity, because it is not tied directly to patient authorizations, and requires duplicate entry which under-resourced agencies do not have the ability to do reliably. The first solution to this problem is for the Department to lay out data specifications and allow agencies to build these into their E.H.R. systems rather than trying to develop its own e-reporting system.

2. Building on the above comment, it makes good sense for the required data to be delivered to the care management entity, rather than to a data system that is uninvolved in daily operations (as is now done with SMART). By making this data part of the care management/authorization system one assures that there is nearly 100% reporting, and that the reporting is relatively accurate because it is tied to the billing system. These are not characteristics of the existing SMART system, which is notorious in the provider community for its lack of validity. Using the OMS data as part of the authorization process has proven very succesful in the PMHS, and it would be good to continue this model, tweaking it to allow agencies to upload specified data directly from their E.H.R.'s if they preferred to do this, rather than having to duplicate entry into a web-based authorization system. This would encourage agencies to use standard outcomes measures internally for ALL their funders, which would improve data quality and utility.

3. The data should be transferred to, presented, and analyzed by an independent, enduring, entity like the University of Maryland. It is extremely frustrating, and organizationally dysfunctional, to have to re-invent the data portal whenever care management is moved to a new entity.

4. In reading these comments, one might wonder what this has to do with the decision on how to proceed with integration. The reality is that the ability to generate good data in an efficient manner is a key variable, and should, I believe, be part of the evaluation of how to proceed structurally.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: 1. In addition to looking at the Maryland data that DHMH is assembling in the template formats distributed, I think it is critical to look at the national 2005 Medicaid data from other states that have implemented the various models we are considering. At the Children?s Behavioral Health Policy Day on April 20, 2012, a distributed powerpoint presentation referred to the Faces Study that analyzed differences in utilization, expenditures and other measures among various state Medicaid management and payment arrangements (comparing Fee for service, capitated managed care etc.). This data should be very instructive in deciding on the model to choose in Maryland. One of the attendees, Rena Mohamed, said she has this data and will provide it. It may also be available through the Mental Hygiene Administration (who organized this event) or on-line. I have also seen references to this data as the Health Care Reform Tracking Project out of the University of South Florida. I have also seen references to the 2005 Medicaid MAX dataset.
2. At the meeting I suggested that the templates also break information down for people with developmental disabilities. I suggest that for template 2a and 2b, the data should also be broken down by whether a person has a developmental disability diagnosis (including intellectual disability, developmental delay, autism, any autism spectrum disorder such as pervasive development disorder or Asperger?s syndrome, cerebral palsy, traumatic brain injury or any other serious physical disability that manifests before age 22). In addition to breaking the data down in all categories by MHD only, SUD only and both, columns should be added for a Developmental Disability Diagnosis (DDD) Only, MHD and DDD, and SUD and DDD.

For Table A listing the HEDIS Diagnostic definitions, the following should be added: ID, DD, Autism (PDD already included), Asperger?s, TBI pre and post age 22.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: I believe this data from the Kaiser Commission should be considered by the workgroup in selecting a model:

The Kaiser Commission on Medicaid & the Uninsured has a 50-state survey of Medicaid managed care initiatives (including capitated MCOs and PCCM models): http://www.kff.org/medicaid/8220.cfm

KCMU also issued a brief on Medicaid managed care for people with disabilities which contains a table summarizing key research at the end: http://www.kff.org/medicaid/upload/8278.pdf. Among the findings in that paper: Although risk-based managed care offers states increased budget predictability, managed care for persons with disabilities has not produced short-term Medicaid savings for states. Medicaid FFS payment rates, on which capitation rates may be based, are already so low in many states that there is effectively no room to extract cost savings by reducing price.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment:

Below are comments regarding the collection of data and the data template distributed at the May 9, 2012 meeting:

a. Data should be created by the state for these analyses and planning. The state should not try to collect the data from MCOs, CMHCs, or other groups. In part, the concern with collecting data from other groups is that there could be variability between groups that provide data.

b. Information on diagnoses is critical (both MH and SA). If there are no data on diagnoses, then the exercise looking at state data may not be an effective use of time.

c. Information on demographics will be helpful. Age should be provided in brackets, not as a mean age.

d. Some metric of outcome (quality) should be included. This could be a patient satisfaction survey (at a minimum). Other measures, if available, would be good to have as well (e.g., hospitalizations, ED visits, etc.).

Thank you for the opportunity to provide comments.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: Because of the fee-for-service nature of the Public Mental Health System that was implemented in 1997, there is a good sense of the probable increase in demand for and cost of services as the population eligible for Medical Assistance increases. The grant based system that has been used for reimbursement for substance use services has not provided that same level of demand based data. How would the need for and cost of substance use services for the MA population be determined to establish the "protected" premium in model 1 or the behavioral health service system in model 2? Is it not possible and perhaps likely that the premium for substance use services will be understated if it is based on historical MA data and that resources that go into the system as a result of the better known demand for mental health services will have to be used to pay for substance use services?

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: 8/8/2012

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: It would be very useful to have the current services and cost of those services that Value Options provides to MCO members so that MCOs can have an idea of the costs associated with carving the population into the MCO. Value Options is required to give this information. It is very difficult to endorse a model without considering that data.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: I am attaching an analysis of per member per month costs for the period from 2002 to 2011 for PMHS Medical Assistance (MA) expenditures and total M A expenditures. Over this period, the PMPM cost for PMHS MA services increased by 12.9% while the total MA PMPM cost increased by 14.2%. While this is admittedly a very gross analysis, I recall hearing at the beginning of this process that the growth within the PMHS under the Administrative Services Organization was not sustainable. But in fact the growth has been less than the growth in the MA system as a whole and PMHS MA PMOPM expenditures as a percentage of overall MA PMPM expenditures are slightly lower in FY 2011 than they were in FY 2002. While I appreciate that there were also concerns about the coordination of care both within behavioral health and across behavioral and somatic health, I am not certain why the ASO system was described as unsustainable in earlier meetings. I will also be following up with a couple of graphs which display this information. Please let me know if you have any questions-I would be happy to provide any assistance that you may want in similar comparisons. Thanks.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: 7/25/2012

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☐ Chronic Health Home

Comment: This information is primarily for the Evaluation and Data Workgroup. Today we discussed the importance of integrating substance abuse, mental health, and somatic care. I wanted to share two resources with our workgroup that may be useful. (Evolving Care Milbank May 2010 and TRI Forum on Integration). Thank you.

Chronic Health Homes Comments

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☒ Chronic Health Home

Comment: I am the director of psychology at Mt. Washington Pediatric Hospital in Baltimore (a pediatric rehab and specialty hospital), and I found the meeting yesterday at UMBC very interesting. Unfortunately, I am getting involved late in the process, and I am trying to catch up as quickly as I can. I am particularly interested in this process and the chronic health homes. We specialize in working with children who have both chronic health conditions and behavioral health needs. We work closely with many of our populations here at our hospital, including children with traumatic brain injury, orthopedic conditions, asthma, diabetes, burn injuries, feeding and GI disorders, and obesity or overweight. We have found that many of these children and families have significant behavioral health concerns, and we work closely with these kids and their families to prevent and to ameliorate behavioral health problems. We are fortunate that much of their specialty medical care takes place here at our hospital, so integrating medical and behavioral care for these children and families is quite natural. Most of these children and families have Medical Assistance.

I am in the process of trying to figure out the best way for me to get involved in this process, and I will continue to read all the material you have made available and attend as many of the meetings as I can. When the time comes for discussion about specific diagnoses and the interface of chronic medical and behavioral conditions in children, I hope to be able to contribute.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date:

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☒ Chronic Health Home

Comment: I also wanted to mention that the adult hematology group at Johns Hopkins has a HRSA grant to develop medical homes for adults with sickle cell disease. Below is a link to their website - there may be some information we can learn from/share with them regarding their model and how that might apply to health homes more generally.
http://www.hopkinsmedicine.org/Medicine/sickle/

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☒ Chronic Health Home

Comment: • Under eligibility - shouldn't this include "2 or more chronic conditions" and "one chronic condition and at risk for another"

- How will notification about health homes and eligibility be given to consumers in ED?
- Add to list of services under patient/family support or community refferal - Wellness Recovery Action Planning - WRAP.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: *de-identified*

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☒ Chronic Health Home

Comment: 1. Methadone programs: the point was made that methadone patients were included, not because of the medication they are on but because of the qualities of the program they are in. Some opiate-addicted patients don't do well on methadone and are instead treated with buprenorphine (Suboxone) or naltrexone (Vivitrol).
SUGGESTION: Do not define this eligibility criterion based on the medication used, but instead describe the program characteristics that must be met. You don't want to establish a perverse incentive to keep people on methadone when they may do better with another valid treatment.

2. Severity Criterion: the PRP diagnostic criteria are limited to mood disorders that are "severe," but the DSM indicates that these are state, not trait, characteristics that change over time and can become moderate, mild, partial remission, and in remission. You don't want people to lose eligibility for a BHH just because they got better.
SUGGESTION: It was suggested by Melissa that these are not "Eligibility Criteria" as stated on the slides, but instead be "Admission Eligibility Criteria." We concur. Also, we would like to see this explicitly stated, along with an explicit statement that people whose diagnosis state (fifth digit in CPT code) improves over time remain eligible as long as they meet the relevant intensity requirements.

3. Transitions: because some patients with severe but episodic illnesses may have reductions in intensity of care needs when in remission, but clearly benefit from the integrated team approach in remaining well, there should be a mechanism to maintain them in the BHH but at a further reduced PMPM level.
SUGGESTION: Since these patients would be expected to require visits only once or twice per month, we suggest adding a fourth PMPM level that perhaps would only count as "half a patient" in the total minimum patient count required for staffing levels, but permit a minimum of once monthly services for a period of time (2 years?) after their latest "severe" episode or hospitalization.

4. Alcoholism: people with alcoholism and another medical condition consume an inordinate amount of resources, especially on the physical health side. A quick analysis of your 2011 HealthChoice data will likely demonstrate a 500-1000% excess of ED visits and hospitalizations for patients with alcohol dependence and withdrawal (303.90-93, 291.0, 291.81-83), often for medically management of withdrawal, seizures, and delirium due to metabolic encephalopathy. These are often lengthy admissions (3-7 days) and sometimes require expensive ICU treatment, especially when combined with diabetes, CHF, COPD, epilepsy, or hypertension. We know there may be some federal constraints, but the bang for the buck is so great, a creative solution must exist.
SUGGESTION: Include "Alcohol Dependence" with a chronic condition and functional impairment as another Admission Eligibility Criterion.

One additional point. The idea of substituting an NP for the PCP came up today. The July slides indicated that the monthly payment for a PCP consultant to be $12.50 PMPM. Extrapolating to determine what an annual salary would be for a full-time PCP (this would require 2000 patients to come to a full-time 2000 hours per year), 2000 x $12.50/mo x 12 months = $300,000. This is plenty to cover a PCP and malpractice, and much more than necessary to cover an NP. Since this is supposed to cover costs, I suggest you consider paying a lesser amount PMPM if an NP is used.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: de-indentified

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: COMMENTS ON APPENDIX IX

Criteria 1
Benefits
Model 2-Item 1: It is noteworthy that some State funded (and these are not all grant funded) services are currently coordinated with Medicaid funded benefits through the ASO. In the PMHS, a majority of state funded services are managed and paid through the ASO.
Model 2-Missing Benefit: A single point of contact for behavioral services is likely to be more familiar with the range of services available in the behavioral health system.
Challenges
Model 1 (4): It may also be difficult for all MCOs to achieve the detailed knowledge of the range of MA and non-MA services available through the behavioral system and how together they might best be used for a given consumer.
Model 1-Missing: Currently, some substance use providers are having difficulty in billing the various MCOs; these problems will be multiplied if the mental health providers also have to bill different MCOs or their behavioral health managers.

Criteria 2
Benefits

Model 2-Missing: The ASO system has a demonstrated capacity for the collection, processing, and analysis of detailed demographic, diagnostic, and outcome data as part of its contract with the MHA.
Challenges
Model 1-Missing challenge: MCOs would have to establish data collection capability beyond claims and current authorization to collected individual behavioral outcomes as well as train practitioners to administer instruments with an appropriate level of reliability. (Note that this will have to be accomplished to meet current federal reporting requirements-while it could be done through an external mechanism, that methodology has proven less reliable and comprehensive than incorporating it into the authorization and payment processes.)

Criteria 3
Benefits
Model 2-Missing benefit: Behavioral health practitioners more versed in developing serious behavioral health issues may receive referrals earlier from the MCOs and therefore might identify and react to developing issues more rapidly.
Challenges
Model 1-Item 2 (suggested rephrasing): MCO primary care practitioners may not be sufficiently versed in behavioral health indicators to identify developing serious behavioral health issues and/or may not have the time to pursue the issues that would bring developing serious behavioral health issues to light.
Model 1-Missing challenge: One must question, given that MCOs are generally part of entities that should be motivated by efficiency and excellent patient care, why the MCOs have not already taken significant steps toward the integration of behavioral care with somatic care. If this strategy works so well to both reduce costs and improve the lives of patients, why has it not happened as a result of these intrinsic incentives. So given that this integration has not been accomplished by the MCOs to date, the level of incentive to make this integration happen is not determined and may be extremely high.

Criteria 4
Benefits
Model 2-Missing benefit: Many current behavioral health providers do treat individuals throughout their lifespan; those that do not usually have established relationships with other agencies to whom they can refer individuals who age out of their services. There are also several specific programs which specialize in working with consumers who are transitioning from child to adult services. Such referral networks could be lost if not all MCOs contracted with all current behavioral health providers.
Challenges
Model 1-Need for expansion of item 2: Consumers who are eligible for Medicare either by virtue of their age or their disability status (which includes many of the most disabled consumers with mental health disabilities) are not currently being served in managed care. This may make it much harder to coordinate care and these consumers may have more difficulty accessing those behavioral health services which are not included in the Medicare benefit but are available either through Medical Assistance or as state only funded services.

Criteria 5
Benefits
Model 2-Missing benefit. Many behavioral health providers have well established current relationships with local consumer groups who can provide valuable assistance with consumer engagement in treatment and rehabilitation services.
Model 2-Missing benefit. The implementation of health homes could provide all of the benefits of Model 1 by identifying those individuals who are identified as having chronic conditions and who are not currently receiving regular somatic care but appear to be using emergency and inpatient services in place of regular treatment for chronic somatic conditions.
Challenges
Model 1-Missing challenge: The current consumer relationships with providers and care continuity could be adversely affected if all MCOs do not contract with all current behavioral health providers, potentially threatening both the somatic and behavioral treatment of some consumers.

Criteria 6
Benefits
Model 2-Restatement: Treating behavioral health conditions in a separate specialty system just as any other chronic condition would be treated would bring the consumer with behavioral health issues into the specialty system sooner and marshal additional behavioral health expertise in the specialty system more quickly. This would potentially lead to better health outcomes for consumers.
Challenges
Model 1-Challenges: While it is possible that Model 1 may lead to better integration of care, there is no assurance that there will be any increase of communication between the MCOs' behavioral and somatic providers. This communication element is essential to maximize efficiency and effectiveness of care. Even with a single shared Electronic Health Record (EHR), there is no guarantee that somatic providers will review the behavioral portions of the chart and vice versa.

Criteria 7-No additions or deletions appear necessary.

Criteria 8
Benefits
Model 2-missing benefit. The ASO system has a demonstrated capability of adapting to other payment systems and service delivery systems. This has happened across multiple ASOs and multiple system changes; examples include the implementation of the case rate for Psychiatric Rehabilitation Programs in 2004, the implementation of alternate payment structures for EBP certified services, and changes to reimbursement for case management services. The ASO has also accepted responsibility for reimbursing services outside of the scope of the original contract at various times and currently pays claims for behavioral services outside of the mental health services identified in their original contract.
Challenges

Model 2-Challenge 2. It might be noted that there have not been major shifts in the definitions in the past 15 years and none are expected, but that they ASO system has been sufficiently resilient to adapt to those changes that have occurred.

Criteria 9
Benefits
Model 2-Missing benefit. Over the history of the ASO program, each vendor has worked hand in glove with the Mental Hygiene Administration in the processes of identifying problem providers and taking appropriate actions to deal with the issues identified, as well as to improve cost efficiency while maintaining quality and effective care.
Challenges
Model 2-item 2 additional observation. Since the inception of managed care, there have always been disputes over hospitalization pre-auths and payments. If this is observed as a challenge in Model 2, there is no reason to assume that it would not present an internal challenge to the MCOs and that would ultimately be appealed to the Department if Model 1 is implemented.

Criteria 10
Benefits
Model 2-Item 3 requires rephrasing. It will be easier to coordinate MA and non-MA behavioral health services that are either grant funded or authorized and paid through the ASO/MBHO. The ASO has a demonstrated history of integrating the authorization of and payment for MA and most non-MA mental health services over the past 15 years.
Model 2-Missing benefit. The local behavioral health authority will have a single entity with which to coordinate the local array of services that is not centrally authorized and paid rather than dealing with several MCOs; similarly, the single ASO/MBHO will be more likely to become familiar with local resources than the 7 or more MCOs will.
Challenges
Model 1-Missing challenge. If MCOs contract with different MBHOs, the coordination of services will become difficult, there will be added administrative costs, and the benefits of having a single manager of care will essentially be lost.

Criteria 11
Benefits
Model 1-Benefit 2. This makes several assumptions including that all MCOs will provide services in the Exchange market and that there will be no turnover in MCOs. (We will see whether the Wellstone purchase of Amerigroup has any impact on the Maryland recipients.)
Model 2-Item 2 restatement: Greater continuity between MA covered services with those either authorized and paid for by the ASO/MBHO or those grant funded through local behavioral health administrations.
Challenges

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: de-identified

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: PRELIMINARY COMMENTS ON FINAL REPORT

Thanks very much for a generally positive report and recommendation. Based on a preliminary review, I have the following comments:

I appreciate the need to emphasize that the new system must allow for true risk sharing at the system and the provider level. However, the phrasing of the caveats on page 5, paragraph 2 and page 21, last paragraph are so strongly worded that they approach accusing the behavioral health advocacy community of bad faith. Many of us who have been active in this process (myself included) have no interest in or benefit from a system that rewards quantity over quality. The provider community is in fact only one part of the larger advocacy community. We have been involved because we believe that Maryland has built an exemplary public mental health system that serves its consumers well and we did not want to see many of the advances that have been made lost to a system change; the intention has been to make certain that any new system will accommodate those advances and continue to encourage them. The phrasing of the caveat does not seem to take that into account.

The second observation I would make (and not for the first time) is on page 24 under quality measures. The report cites the usual set of somatic measures. Even with their expansion, measures such as the HEDIS are woefully inadequate in assessing quality in a behavioral health

system. It is somewhat disappointing and perhaps worrying to have any and all measures of consumer quality of life relegated to "and others".

Thanks for the opportunity to comment.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter:

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: COMMENTS ON DRAFT FINAL REPORT

1. Page 5, third bullet, indicates that the MHA operates a fee-for-service Medicaid financed program for specialized mental health services. I realize that this report focuses on Medicaid funded services; however, it also refers (often not completely accurately) to grant funded state financed services. These statements miss an important strength of the PMHS, that the MHA fee-for-service system integrates the authorization of and payment for both Medicaid-funded and State only funded services. This allows for centralized and consistent coordination and authorization of these services, many of which are authorized and rendered in conjunction with one another. While it is true that MHA does still have some State only grant funded services which are not part of its fee-for-service system, a very large part of the MHA's state only funded services are administered through the fee-for-service ASO system.
2. In conjunction with this observation, the strengths of the current mental health system do not seem to be articulated as clearly as one might have hoped and as you indicated that they would in the next to last large workgroup meeting. Maryland's PMHS is one that mental health advocates in many other states would very much like to duplicate; this was recognized in the NAMI rating of the Maryland system. The structure has allowed for the differential payment for (and wide implementation of) Evidenced Based Best Practices. As a result, Maryland's EBP Supported Employment program has been able to continue to trend that it really began in the 1990s of being a model for the nation. Maryland's ASO currently maintains

a pharmacy system that includes both somatic and behavioral medication information on all Medicaid recipients and is accessible to all prescribing MA physicians-behavioral and somatic. The ASO also provides information to all MCOs on services that are authorized for recipients in their programs. Maryland's ASO system has also allowed very quick access to authorization and claims payment information, along with significant outcome information on most of its recipients. These are the kinds of strengths of the PMHS that would be appropriate for inclusion in the report; one would hope that a major objective going forward would be to maintain the gains that the system has allowed Maryland's PMHS to make.

3. Page 7- Health Care Reform and Behavioral Health. Again recognizing that this is primarily a report based on Medicaid funded services, the expansion of Medicaid eligibility will do nothing to cover the costs of essential residential, educational, and employment services that are clearly not part of the behavioral health benefit but that are essential for the recovery process in behavioral health. One hopes and assumes that these services will continue to be funded with State only funds.

4. Page 12 – Paragraph 2 does not address the collection of data sufficient and sufficiently timely to assure the "protected benefit". The MCO history of reporting of substance use treatment services and expenditures do not provide a great level of comfort in having the necessary treatment and expenditure information going forward to assure a protected benefit.

5. Page 12 – Paragraph 3 does not address the costs that would be incurred by the MCOs hiring BHOs. It would appear that this would result in an increase in administrative costs, one paid to the MCOs and another to the BHOs.

6. Page 14 – Paragraph 1 refers to State funded services again as "grant funded". See #1 above.

7. Page 14 – Paragraph 1 articulates difficulty in the system keeping up with changes in the definition of primary and specialty care. In the outpatient world, this has never really been an issue. The guiding principle promulgated by the PMHS from the outset of the HealthChoice program has been "When in doubt, refer". Early intervention leads to much better treatment options and outcome for the consumer, usually at decreased costs when compared with interventions that occur later.

8. Page 14 – Paragraph 5 does not appear to allow for the potential impact of health homes on those individuals with the most serious health problems; one potential solution to many of the issues that have been identified and that are the basis for this effort would be to find those recipients with behavioral health issues who are high users of inpatient and ED services and who are not engaged in routine health care and to attempt to enroll them into health homes.

9. Page 19- Eligibility "churn" fails to recognize that many individuals who are have a disability and a work history are Medicare recipients whose SSDI payment level is sufficiently high that they have spend down requirements to obtain dual coverage; consequently, many disabled individuals are in spend down categories rather than disability categories because their work history entitles them to Medicare coverage. Ironically, the poorer Medicare coverage usually replaces a more generous Medicaid package since the individual is usually on Medicaid for two years, the waiting period for Medicare eligibility. I have not heard a great deal about what is expected for this population under health care reform, though in most cases, the SSDI payments which are above the 113% of poverty level are likely to be below the 139%, which

will allow these individuals to maintain dual eligibility. This will alleviate a great deal of the churn that exists today.

10. Page 20 – Benefit flexibility might offer some advantages but some of the most direly needed services, almost certainly housing and very probably extended vocational supports, would very likely not be allowable services.

11. Page 20 – Direct Relationship with providers paragraph appears to indicate indicates that the ASO currently has no direct relationship with providers. This is not completely accurate; the ASO has considerable responsibilities regarding the providers. Further, the ASO at the direction of MHA currently pays differential rates to providers who meet fidelity for certain EBPs. MHA/DHMH can terminate sufficiently "bad" providers under the current system, though it is not generally an easy or quick process unless there is an egregious violation.

12. Page 21-It would help if the first paragraph (which began on the page before) also indicated that Model 2 allowed the continuing integration of many State-only funded behavioral (mental health) services with Medicaid funded services (see #1 above).

13. Page 22-Care coordination paragraph seems to imply that new requirements will have to be placed on the BHO but is silent on the need to add requirements on the MCOs. To be effective, coordination must be a two way street and the MCOs' contracts will also need to have additional requirements.

14. Page 22-Incentives. It seems that if the sizeable savings in emergency room and inpatient treatment were so readily available to the MCOs simply based on the coordination of behavioral and somatic care, that this coordination would have occurred by this time. Coordination is certainly necessary; is there any room for doubt that these savings will materialize?

15. Page 22- Payment disputes paragraph indicates that there will likely be payment disputes going forward; these disputes have existed and been resolved throughout the 15 years of the current HealthChoice program; moving substance abuse into a BHO will to some degree reduce these disputes because substance use advocates have promulgated the message that the way to an inpatient stay was to indicate that one was going to an ER and saying that one was going to kill himself/herself or someone else.

16. Page 23-Quality measures, while only given as examples, do not include many of the types of life domain measures that are important in behavioral health (and that will likely have to be reported to a federal entity) such as housing status, school/employment status, recovery status.

17. Page 23-Provider rates paragraph raises the question of whether there is an intention to change the current rate structure. The definition of "Medicaid's FFS rates" is what is at issue. MHA has traditionally set provider rates for the PMHS which are not the rates for these services which are paid by Medicaid or the MCOs.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: de-identified

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: COMMENT ON DRAFT REPORT

Thanks for a report that at least upon a cursory review is really excellent. There is one addition that might be considered. On page 18, there is reference to Model 2 being "adaptable when demographic factors change". I would suggest that thbe report reflect that individuals with a work history who have been determined as eligible for SSDI benefits, regardless of age, also become eligible for Medicare 2 years after the initial determination. A large group of the behavioral health fee-for-service population falls into this category if they are fully dually eligible or if they become eligible as a result of spend down.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: de-identified

Organization:

Date: Click here to enter a date.

Contact Information:

Related Workgroup(s) (if applicable):

- ☐ Systems Linkage
- ☐ State/Local and Non-Medicaid
- ☐ Evaluation and Data
- ☐ Chronic Health Home

Comment: Thank you so much for your efforts.

For three years I served as the Clinical Director of a Mobile Treatment Service, caring for 350 patients with serious and persistent mental illness and I currently serve as the Clinic Director for a group of substance abuse/methadone maintenance providers caring for approximately 1500 clients. Between these two positions I have worked with a significant number of the most vulnerable of the mental health and substance abuse treatment consumers.

I would like to share five thoughts:

(1) The complete integration model assumes providers will respect and work together across disciplines. In daily practice however, that is hardly the case. Providers across disciplines often disregard recommendations and coordination efforts.

(2) Complete somatic, mental health, and substance abuse integration is a great goal to achieve one day, however, I do not think the Public Health system is ready for all three at once. I would suggest taking the integration effort slower and first focus on completely integrating mental heath and substance abuse. That will be much easier to accomplish. Once behavioral health is one unit, it will be easier to properly integrate with somatic care.

(3) Mental health and substance abuse treatment consumers tend to have a low threshold for anxiety and delays. The current wait time and hassle involved in accessing primary care in the public system is a deterrent on its own. Before any somatic integration, I would work to improve the basic stand alone access to primary care. I currently refer people on a daily basis to get physical exams, they need to wait weeks, and it doesn't end up happening.

(4) In a fully integrated model, who documents medical necessity? What happens if primary care says the person does not need mental health treatment but a mental health provider would disagree? This is a source of fear for behavioral health providers.

(5) SUGGESTION: From a management perspective, it is safe to assume that the coordination of multiple disciplines is best achieved under a single management structure with established policies for coordination. This seems impossible on a state level as medical directors across the State are bound to have many different philosophies. I would suggest providing incentives for the management of current providers to join with others on an individual basis and establish their own integrated systems. That way there will be inheriht coordination under one management structure. We are currently opening more substance abuse clinics, we will probably open up integrated mental heath services, but we would need some incentive to help make partnering with somatic care financially feasible.

Behavioral Health Integration: Public Comments Form

Instructions: Please submit your comments regarding behavioral health integration using this form. Enter as much information as possible and check all boxes that apply. Please note that the use of this form is voluntary and we will accept all comments in any form. You can submit comments via email to bhintegration@dhmh.state.md.us or via fax to 410-333-7687. We appreciate your feedback!

Commenter: Greg

Organization: Warren

Date: 9/20/2012

Contact Information:
Baltimore Substance Abuse Systems, Inc.
One N. Charles St., suite 1600, Baltimore, MD 21201
410-637-1900

Related Workgroup(s) (if applicable):

- ☒ Systems Linkage
- ☒ State/Local and Non-Medicaid
- ☒ Evaluation and Data
- ☒ Chronic Health Home

Comment:
As recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA), Integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly.
The following are principles we look forward to discussing with DHMH in the coming months.

Principles:

1. The total person needs to be cared for. We need to insure that the linkage and integration, not just the coordination of care, is strengthened between behavioral health and somatic care.
2. Insure that the entire public health system serve as access points to behavioral health care.
3. Supports integration of Care not just Coordination. The intent here is that the patient views their healthcare providers as being united in treating them as a whole person.
4. Information is shared between the MCO's and the ASO/MBHO and there are financial incentives that link quality outcomes between behavioral health and somatic care

5. Supports Parity. We need assurance that carving out behavioral health does not jeopardize parity for substance abuse disorders
6. Costs can be controlled and incentivized for better outcomes such as ED visits and Hospital stays.
7. There needs to be an expectation that the ASO/MBHO and the MCO's have IT and Care Coordination connectivity for patients with behavioral health and somatic needs. At the very least, as a phase in process, initially with the high cost, frequent users within each "system".
8. Holistic outcome data that also has the ability to connect to (Healthy Baltimore 2015, Neighborhood Health Profiles) and other data points within a jurisdiction's public health system
9. Improved outcome data for co-occurring population
10. Health Homes should be able to accept and care for individuals suffering from behavioral health issues.
11. Encourages and provides a pathway for the creation of the financial infrastructure to establish ACO's
12. Promotes screening and assessment of MH and SA disorders as a method to decrease hospital re-admits and that should be MCO reimbursable
13. Performance incentives should be put in place that encourages the ASO/MBHO to innovate and improve quality for consumers.
14. This model should be committed to removing stigma and promotes substance use disorder as a chronic health condition that is treated like any other chronic health condition.
15. This model should be a first step towards the ultimate goal of a fully integrated behavioral health and somatic care systems across all levels of care.
16. DHMH should insure that this model have the expectation to promotes the implementation of preventative services at primary care sites.
17. This model should promote a more seamless transition protocol for those churning in and out of Medicaid and into the Exchange.
18. Substance abuse treatment funding needs to be tracked and outcomes such as access and the number of patients treated across the existing levels of care need to be monitored in order to ensure "protection"
19. DHMH should act with expediency in amending the contractual expectations of the MCO's so that they are obligated to report data and partner with the ASO/MBHO
20. The existing substance abuse prevention and treatment workforce must be respected
21. Workforce development and cross training should initiated in order that SA Certified counselors and mental health licensed clinicians can become more co-occurring capable
22. Managed care staff should have sufficient training and experience and be trained in ASAM patient placement criteria.
23. Block Grant funds should not be reduced further in order to protect non-medicaid reimbursable services such as residential treatment, criminal justice care coordination, peer recovery supports and innovations in evidence based practices that meet specific jurisdictional needs.

Jurisdictional Oversight 1. Merging core service agency functions with Block grant oversight

2. Proxy to State oversight of accreditation compliance, claims grievances and quality of care
3. Ability to support or decline any willing provider for Medicaid claims ability
4. Ability to incentivize continuity of care across public health, education and criminal justice systems
5. Ability to perform strategic planning and needs assessment
6. Allows for local input into systems of care that are sensitive to jurisdiction and community needs