

BEHAVIORAL HEALTH INTEGRATION PRINCIPLES FOR DECISION MAKING

The new system should promote recovery to the greatest possible extent. This means that the “right service” in criterion #1 produces not only good clinical outcomes but functional outcomes related to factors such as employment and housing, consistent with a public health approach.

There should be incentives for coordinating somatic and behavioral health care, including health home-type reimbursement mechanisms for whole-person care coordination as well as financial incentives to reward integrated treatment planning and delivery.

The system should ensure inclusion of historic behavioral health providers. Historic provider protections were included in the design of HealthChoice, including requirements that historic providers have opportunities to contract with managed care organizations. This is essential for continuity of care and ensures that those providers with the greatest amount of experience will be able to participate in the new system.

The system should not marginalize individuals with behavioral health needs. One of the concerns with a population carve-out is that individuals with the greatest behavioral health needs will be further marginalized, stigmatized, and underfunded.

Adequate resources must be invested for behavioral health needs. As the new system is designed, it should incorporate a more rigorous rate-setting process for behavioral health services, including actuarial soundness, similar to that which is in place for Medicaid MCOs.

Savings from reduced inpatient and ED utilization should be shared with providers and invested back into the system (as opposed to going to profit margins). Indeed CBH strongly supports the Mental Health Association of Maryland’s recommendation to add criterion #11 included in their comments. The state should consider the option of having a nonprofit entity operate the new behavioral health system.

The system must be flexible and porous enough to accommodate changing behavioral health needs as conditions improve or are exacerbated. One of the strengths of the current public mental health system is the ability to increase or decrease

services and supports as an individual's needs change. This flexibility should be preserved in the new system.

There should be protections against "dumping" in the new system. Another concern about a population carve-out is that diagnoses may be altered to dump individuals whose treatment is becoming expensive onto the carve-out.

The locus of treatment for individuals with high behavioral health needs (quadrants II and IV) should be with the behavioral health provider. The SAMHSA quadrant model is helpful in thinking about the locus of treatment for individuals served in the new system. For individuals whose greatest need is behavioral health services, the health home should be the behavioral health provider.

The system should promote best practices and focus on outcomes. We endorse the Mental Health Association of Maryland's comments on criterion #5 but would add that the current behavioral health system's prescriptive, process-oriented approach to quality management must be replaced by one that focuses on consumer outcomes and aligns performance incentives with the achievement of agreed-upon outcome benchmarks.

Mental health stakeholders are in agreement that the mental health community is the only one with the experience and expertise to provide high quality whole-person care. Indeed a strength of community providers operating now within the PMHS is a demonstrated clinical effectiveness and cost-efficiency in assisting individuals with challenging and often disabling psychiatric conditions to recover and to function as productive independent citizens. The growing experience of many community behavioral health providers in embedding somatic care capability in the community mental health setting is already expanding that effectiveness to whole-person disease management through health home-type approaches that not only help improve overall health but reduce use of higher-cost inpatient and emergency department care. Thus, CBH at this point is inclined to favor option 2 but is interested in a managed behavioral health structure that includes some level of responsibility for the whole person. This certainly means that community mental health providers should be the health homes for individuals with higher level mental health service needs. Whether that involves assumption of financial risk is an issue that requires further analysis.

CBH has concerns about option 3 as stated because of the potential pitfalls of a "population" as opposed to a "service" carve-out. These include: 1) a population pool that may be too small to be sustained via the kind of capitated funding arrangement that may be proposed; 2) disruption of continuity of care as individuals recover and move out of a specialty environment but who may well need such an environment in the future as is often the case with the cyclical nature of mental illness and addictive disorders; 3) in the absence of real risk-adjustment mechanisms within behavioral health, the danger that consumers will be relegated to the wrong care setting based on financing instead of need.

As for the status quo, DHMH leaders have made it clear that that is not an option. However, as the Mental Health Association of Maryland has commented, we should

identify the strengths of the current system and build them into the new integrated system. That said, there are aspects of the current system that community providers feel should not be preserved: 1)the fee-for-service reimbursement process is far from cost-based and doesn't even build in true inflation. As such it stunts growth, inhibits the recruitment and retention of staff, provides no resources for infrastructure and threatens agency survival long-term; 2)the current process-oriented administrative management structure of the PMHS absorbs far too many resources that should be devoted to services and does very little to reward providers for producing good outcomes; indeed, recovery-oriented cost-effective consumer outcomes often take a back seat to regulatory compliance as viewed and enforced by far too many overlords.

Thank you for considering our views.