The Maryland Addictions Directors Council

NCADD MARYLAND

November 9, 2012

The Honorable Joshua Sharfstein, M.D.
Secretary, Department of Health and Mental Hygiene
Office of the Secretary
201 West Preston Street, 5th Floor
Baltimore, Maryland 21201-2301

Re: MADC and NCADD-MD response to *An Integration Model for Medicaid-Financed Behavioral Health Services-* ***Request for Reconsideration***

Dear Secretary Sharfstein:

We are writing to share our response to the final report and recommendation from the steering committee entitled, *An Integration Model for Medicaid-Financed Behavioral Health Services* (Final Steering Committee Report) delivered to you on October 1, 2012. We are disappointed by the recent release of the recommendation that was a significant shift from what was presented on September 13, 2012. The Final Steering Committee Report has been negatively viewed by substance use disorder stakeholders and advocates who have invested a great deal of time and effort into the process that unfolded. More importantly, the recommendation is not consistent with the genuine promise of whole-person health care offered under the Affordable Care Act (ACA), nor is this in keeping with Maryland's reputation of being in the forefront of innovation.

Our organizations support a fully integrated, person-centered public behavioral health system that integrates general medical health care and behavioral health care at the point of service, relies on the clinical judgment of behavioral health professionals and advances measurable improvement in health outcomes. The final recommendation represents a system that reinforces the status quo, is backward looking and does not reflect best practice surrounding the integration of behavioral and somatic health care. **The recommendation addresses system dynamics, rather than the needs of individuals seeking care.**

The most urgent issues surrounding the final recommendation are:

- **The Transformative Administrative Service Organization (ASO) Model presented does not ensure public dollars are effectively or efficiently utilized for behavioral health services.**

A 2009 report by the Lewin Group which reported on a synthesis of 24 studies of managed care Medicaid programs found that "Medicaid managed care health plans improve beneficiaries' access to services and have earned high satisfaction ratings from enrollees, in addition to improving care and saving money." The consultant's report presented to the Department of Health and Mental Hygiene (DHMH) on December 11, 2011, *Future Options for Integrated Behavioral Healthcare* (Consultant's Report) recommended the adoption of a risked-based, managed care model in any option adopted by DHMH to reduce waste, improve outcomes and achieve efficiencies. Adding performance risk to the ASO contract was recommended only as an interim step to achieving true integration and accountability.

The Final Steering Committee Report lacks any specificity regarding how DHMH will incorporate performance incentives into the proposed system. Further, the final recommendation notes that the details related to a "transformative ASO" premised on "pay-for-performance, outcomes and value based purchasing" will be determined in phase three of the process. Throughout the process important questions have been addressed in the exact same manner.

It is not acceptable that such important matters are not informing this recommendation. There is a total absence of data or support that demonstrates that the transformative ASO model will improve outcomes or bend the cost curve.

- **Innovative and improved care is not achieved in a separate, fee-for-service system.**

The final recommendation acknowledges the "lack of direct integration between somatic care (including primary care) and specialty behavioral health services." The stated challenges include the need to develop a care coordination system, the likelihood of payment disputes, the barriers to achieving shared savings between somatic and behavioral health systems, inability to easily incorporate prevention practices in primary care and the lack of common data platforms. As noted in the Consultant's Report, a transformative ASO fee-for-service model "requires workarounds to build incentives to integration externally." Additional resources would need to be allocated to fund the necessary care coordination, incentives for prevention and administrative support to develop and implement system "workarounds."

It has been argued that an integrated managed care organization (MCO) model may lead each MCO to subcontract with multiple managed behavioral health organizations (MBHO) and create more fragmentation of services. There also may be incentives for MCOs to reduce and eliminate services in order to increase their profits. DHMH has the power to address these concerns in its contracting to ensure MCOs provide genuine integration. In the *MADC Consensus Document Regarding DHMH Behavioral Health Finance Integration Models*, we outline a list of conditions that would address this concern.

- **The Final Steering Committee Report removes substance use disorder services from the integrated MCO system of which they are currently a part.**

For over two years, substance use providers have been providing services to Medicaid recipients, billing HealthChoice MCOs and working with MCO care managers to help access health services for their clients. Although there have been challenges working with multiple MCOs, providers report that progress has been made and many problems have been addressed. MADC members have reported, "We have worked out many of the issues and they are responding faster than ever." Providers have invested in billing systems that can be utilized in payment for Medicaid, as well as private insurance. This progress will be even more useful as the Health Benefit Exchange is launched and more Marylanders will be covered by private insurance. Providers report that the majority of their clients have serious physical health issues. The current system allows providers to access MCO care coordinators for their patients who ensure coordinated medical treatment. As noted in the Consultant's Report,

> *Given the increase in access to addictions treatment achieved in the Medicaid expansion through PAC, it would be step backwards to carve out the SUD benefit, only to carve it back in within a relatively short period. There would be significant State effort required to either re-scope or re-bid the ASO contract; this effort would be better spent on creating a blueprint for integrated benefits management and care.*

- **Parity is not legally required in a behavioral health ASO arrangement.**

A legal analysis of the Mental Health Parity and Addiction Equity Act of 2008 by the Drug Policy Clinic of the University of Maryland Francis King Carey School of Law entitled, *The Application of the Mental Health Parity and Addiction Equity Act (MHPAE) to A Medicaid Carve-Out for Substance Abuse Services* concludes that:

> *MHPAEA would not apply to the delivery of substance abuse treatment under Maryland's existing carve-out model. Accordingly, if the State moves forward with a carve-out of substance abuse services, it will remove protections that now require substance abuse benefits to be on par with medical/surgical benefits.*

Only Medicaid MCOs with **prepaid** contracts must comply with the MHPAEA. Parity does not apply to an ASO due to the fact that it does not accept a prepaid, capitated payment for specific covered lives in exchange for delivering a prescribed benefit package.

This issue is particularly concerning to the substance use disorder community because substance use disorder services have been historically stigmatized - even within behavioral health. It was only after the 2008 Parity Act was implemented that substance use disorder services were covered as part of the MCO managed Medicaid Primary Care program waiver. Under the current administration, consumers of Medicaid funded mental health services have enjoyed a rich benefit. However, without the legal protection of mental health parity, these benefits could be lost due to unknown changes in the future landscape.

The rationale for a separate ASO, fee-for-service system in the 1990s was that behavioral health services were not treated equally to somatic services. With the passage of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act, inequities are no longer legal. As noted in the Consultant's Report, "having legally required parity across general medical and behavioral health benefits presents an opportune time to attempt to use a more holistic approach to managing care for persons with co-morbid medical and behavioral health conditions." As long as we continue to separate behavioral health from other health services, it will continue to be stigmatized and treated as less important. **There needs to be one system that equally and adequately addresses all health needs.**

- **The recommended model creates a serious challenge to adopting a culture of integration.**

When one organization (the MCO) bears insurance risk and the other (the ASO) does not, there may never be enough independent contract conditions to align the incentives in an equitable fashion. Without financial risk, the MCO has little incentive to expend resources to ensure better behavioral health outcomes or to expend resources on coordination of care. Since the ASO does not bear the risk, it will only provide services to the extent that the service it provides is covered by the fee-for-service contract. There is little flexibility in providing integrated services that are not specifically covered in the ASO contract.

Further, when two separate entities are responsible for management and payment of physical and behavioral health services, there is a natural inclination to point to the other side for responsibility. Behavioral health disorders have historically been treated as different from other health needs and separating payment systems reinforces this practice. Because the two entities do not collaborate to manage care, patients are likely to suffer inequities in treatment limitations, have more restrictive authorization procedures and limited access to care as a result of inadequate clinician networks. This separation further contributes to poor access to somatic care and the foreshortened lifespans for people living with substance use disorders and serious mental illness.

- **The recommended model does not facilitate and support screening and prevention services provided in primary care settings.**

The use of screening and prevention services in primary care practices is an extremely cost effective way of addressing substance use disorders. Substance use disorder professionals are transforming their practices and partnering with primary care providers to provide these important services. These partnerships are facilitated through an integrated MCO system that incentivizes prevention.

A system that has a separate fee-for-service ASO for behavioral health would provide no incentive for the MCO to cover prevention services. Without adequate prevention services, more individuals will develop substance use disorders which will need to be treated with more expensive services. Reducing the incentives to provide prevention services hurt individuals and increases the costs to the system.

- **The somatic needs of persons seeking substance use disorder treatment are significant and distinct from the needs of many individuals with serious mental illness.**

The majority of individuals receiving treatment for substance use disorders present with significant somatic health issues that need to be simultaneously addressed. Those with opiate addictions generally have complicating health issues that need immediate attention. Currently, under the MCO system, providers utilize the MCO care coordinators to assist patients in immediately accessing the services they need. By contrast, individuals with serious mental illness often present with chronic health needs such as diabetes and heart disease that need to be addressed on an ongoing basis. Those cases may be ideal for a health home model which can address chronic care issues. However, for individuals who are currently receiving substance use disorder services through the MCO system, it would be a step backwards to have to navigate two different systems in order to address their serious and acute health needs.

We strongly urge you to reject the recommendation made by the Steering Committee. The recommendation does not support person-centered care, address the cost-curve or reflect the spirit of the State's effort toward advancing health care reform. The recommendation is not informed by the innovative opportunities presented by the ACA, the development of the Health Benefit Exchange or the expansion of health homes. **We request a further review of the extensive documentation and diverse positions put forth. We believe that a full and fair analysis will lead you to the conclusion that providing quality care for the individual patient can best be achieved in a fully integrated, managed care model.**

Tracey Myers-Preston
Executive Director
MADC

Nancy Rosen-Cohen
Executive Director
NCADD-MD

Below are links to documents that MADC has submitted throughout the stakeholder input process:

http://madc.homestead.com/MADC_Response_to_Behavioral_Health_Integration__A_Closer_Look_at_Three_Models__FINAL_8-20.pdf

http://madc.homestead.com/MADC_Consensus_Statement_Regarding_Behavioral_Health_Finance_Integration_Models.pdf

http://madc.homestead.com/MADC_Response_to_Draft_Report_for_Recommending_an_Integration_Model_for____.pdf

cc: Governor Martin O'Malley

Charles Milligan, J.D., Deputy Secretary, Department of Health and Mental Hygiene

Gayle Jordan-Randolph, M.D., Deputy Secretary, Behavioral Health & Disabilities

Members, Behavioral Health Financing and Integration Options Steering Committee:

- Patrick Dooley, Chief of Staff & Assistant Secretary for Regulatory Affairs, DHMH
- Brian Hepburn, M.D., Executive Director, MHA
- Laura Herrera, M.D., M.P.H., Chief Medical Officer, DHMH
- Daryl Plevy, Deputy Director, MHA
- Kathleen Rebbert-Franklin, LCSW-C, Acting Director, ADAA
- Tricia Roddy, MHSA, Director of Planning Administration, Medicaid
- Susan Tucker, Executive Director of Health Services, Medicaid

Members, Senate Budget & Taxation

Members, House Committee on Appropriations

Members, Senate Finance Committee

Members, House Health and Government Operations Committee

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