

**Recommending an Integration Model for Medicaid-Financed
Behavioral Health Services**

Department of Health and Mental Hygiene
Draft Report for September 13, 2012 Public Session

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Introduction

This report reflects significant input from hundreds of Maryland stakeholders, and the committed efforts of many individuals across the Department of Health and Mental Hygiene (Department). It builds upon work conducted by the Department in 2011 that culminated in a consultant report that recommended Maryland should better align and integrate behavioral health services.

The recommendation of a model for Medicaid-financed behavioral health services presented in this report represents the completion of Phase 2 in a three-phase process, namely, the selection of a model to integrate care. Significant work still lies ahead to execute this model, and to develop and revise the various procurements and contracts implicated by this recommendation. The Department greatly appreciates the contributions of everyone who has participated thus far and we look forward to continuing to work with stakeholders in the coming months to improve health care in Maryland.

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Executive Summary

[[to be written in final version of report for September 30, 2012]]

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Background

The Need for Integration in Maryland

There is significant overlap between individuals with mental illness and those suffering from addiction; experts advise that “Dual diagnosis [mental illness and addiction] is an expectation, not an exception.”¹ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that only 7.4 percent of individuals in the United States with co-occurring disorders are treated for both conditions and more than half do not receive treatment for either. In addition, many with mental illness, addiction, or dual diagnoses have significant chronic, somatic health conditions such as diabetes or heart disease. These conditions are largely responsible for the significant gap in life expectancy between those with serious behavioral health disorders and those without.

Maryland’s current financing and delivery system has many commendable attributes, including greatly improved access to care in recent years in each separate domain (mental health, substance use, and somatic services). However, care across these domains often is fragmented, which poses unique difficulties for consumers with complex health conditions seeking treatment in two or more health systems:

- Medicaid pays for somatic treatment and some behavioral health services in primary care settings;
- Local jurisdictional grants provide access to addiction services; and,
- The Mental Hygiene Administration operates a fee-for-service Medicaid-financed program for specialized mental health care services.

These disparate paths too often fail to connect to provide coordinated care for consumers. The combined cost of medical care, substance abuse treatment, and mental health care for high-cost, high-need individuals can reach hundreds of thousands of dollars per person per year, and many co-morbid conditions are left untreated. Moreover, providers in one system often are unaware of services in other systems. An incentive to deliver preventive care in one system might not be strong enough if the resulting savings benefit another system. For all these reasons, and more, Maryland must improve the efficiency and efficacy of our care systems, not only for consumers with serious behavioral health needs, but also for individuals with more routine health care needs.

Overview of the Current System

Maryland is not unique in the fragmentation of its publically supported behavioral health care system. Though all three contracting and oversight entities (Medicaid, Alcohol and Drug Abuse Administration, and Mental Hygiene Administration) are located within the Department of Health and Mental Hygiene, each has independent funding streams, management structures, and payment arrangements. As a result, consumers currently navigate multiple systems in order to receive somatic and behavioral health care.

Somatic Care

¹ Minkoff, K., and C. Cline. (2004). Changing the World: Integrated Systems of Care for Individuals with Co-Occurring Disorders. *Psychiatric Clinics of America*, 27(4).

Approximately 80 percent of all Maryland Medicaid beneficiaries receive somatic health services through a managed care organization (MCO). In fact, participation in managed care is mandatory for most Medicaid beneficiaries in Maryland. Maryland's HealthChoice and Primary Adult Care (PAC) programs, authorized by Medicaid's 1115 waiver, are responsible for providing somatic care to all enrollees through a risk-based, capitated payment system. As of August 2012, seven MCOs were participating in the HealthChoice program, with five of those seven participating in the PAC program. Providing managed care in Maryland requires ensuring access to services, meeting certain quality measures, collecting and analyzing encounter data, and participating in performance improvement projects as defined by the Department. Any MCO that meets the standards set by the Department can participate in HealthChoice; any HealthChoice MCO can participate in PAC.

The remaining 20 percent of beneficiaries receive their somatic care through a fee-for-service (FFS) system. Populations whose services are paid FFS include individuals over the age of 65, dually eligible for Medicare and Medicaid, living in institutions, in the Rare and Expensive Case Management (REM) program, or on certain waivers.

Mental Health Care

All Medicaid beneficiaries may receive primary mental health services from their primary care provider. These include a clinical evaluation and assessment of services needed, as well as the provision of services and referral for additional services. Specialty mental health care is carved-out into a managed FFS program, which has been provided by an administrative services organization (ASO) under contract to the Mental Hygiene Administration (MHA) since 1997. MHA is responsible for providing all medically necessary specialty mental health services neither delivered by the primary care provider nor managed by an MCO. All Medicaid beneficiaries, both those in managed care and in FFS, can receive services through the specialty mental health system. Mental health services for the uninsured are paid with state funds through the ASO. The ASO's responsibilities include operating a utilization management system, paying claims, providing data collection and management information services, offering public information, consultation, training, and evaluation services, and managing special projects.

MHA is responsible for planning, managing, and monitoring the Public Mental Health System in Maryland, and it delegates this authority to Core Service Agencies (CSA) at the local level. The CSAs provide information and referrals, handle complaints, and monitor contracts. They are engaged in collaboration with other systems, develop innovative services, and monitor providers for compliance and quality. The CSAs and the ASO may authorize health services, coordinate care, and manage costs.

Substance Use Disorder Treatment

The Alcohol and Drug Abuse Administration (ADAA) is responsible for the planning, coordination, and regulation of the statewide network of substance use disorder prevention, treatment, and recovery services. ADAA provides state-funded grants to the 24 local jurisdictions and Baltimore City, largely through the Local Health Departments (LHD). ADAA grant dollars cover services for the non-Medicaid eligible population as well as non-reimbursable services for the full Medicaid and PAC populations.

LHDs provide a wide array of substance use disorder services which are funded through a combination of State (ADAA and other agency), local and Federal grant dollars, and client fees. LHD Jurisdictional Coordinators plan a continuum of services specific to the assessed needs of their jurisdiction. They can provide services directly, contract with community-based private and non-profit providers, or combine

direct and procured services for both Medicaid and non-Medicaid reimbursable services. All contracted providers assess a fee for service based on the client's ability to pay, and determine if a client has PAC or MA prior to billing the jurisdiction or using ADAA grant dollars.

Medicaid reimburses a limited amount of substance use disorder services for its managed care recipients. Beneficiaries enrolled in the PAC program are covered for a comprehensive assessment, outpatient, intensive outpatient, and opioid maintenance treatment. The HealthChoice program covers these services, as well as partial hospitalization, youth residential and inpatient treatment, and medically managed inpatient detoxification. Those in a Medicaid managed care program self-refer to substance use services. Services not covered by full Medicaid or PAC are covered by funding sources described above. Some examples of non-Medicaid reimbursable services include: information and referral, prevention, residential treatment for adults, and recovery support services, as well as coordination of care between other service systems and system management.

Health Care Reform and Behavioral Health

Individuals with behavioral health needs often face barriers accessing care in both the private and publically-funded insurance systems. Many private insurers lack behavioral health coverage altogether, while publically funded services remain fragmented and difficult to navigate. Additionally, many low-income individuals without children or above Medicaid's income threshold are ineligible for services despite an apparent need. The implementation of health care reform under the Affordable Care Act (ACA) provides an opportunity to address these issues and significantly improve access to quality care for those with behavioral health care needs.

Beginning in 2014, provisions in the ACA will allow Maryland to expand Medicaid eligibility to most individuals under 138% of the federal poverty level (FPL), and these individuals will qualify for Medicaid's behavioral health benefits. In addition, Maryland's state-operated health benefit exchange will require all participating health plans to cover the ACA's "essential health benefits", including behavioral health services. The need for grant-funded services is expected to decrease as private and public insurance coverage extend to many of those individuals who now lack health insurance; indeed, Medicaid will likely become the dominant payer of health services for low-income individuals beginning in 2014.

The Integration Process

As part of the State FY 2012 budget (for the fiscal year July 1, 2011 – June 30, 2012), the Maryland General Assembly asked the Department of Health and Mental Hygiene to convene a workgroup and provide recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues." In making this request, the General Assembly recognized the current need for improved coordination in Maryland's approach to individuals with behavioral health conditions.

Consultant Work in 2011

In 2011, the Department engaged an experienced consultant to examine the current system, consider integration options, and provide recommendations regarding financing structures to best support integrated care. The consultant conducted five structured interviews with mental health and addictions

treatment providers, consumers, families, advocates, CSAs, and state officials. These interviews focused on two key questions:

- What would an integrated system in Maryland look like in terms of practice, delivery platform, benefits management, and financing?
- How could Maryland move to an integrated system?

The consultant reviewed other states' experiences and identified innovative approaches that would achieve the three goals of effective health care delivery: a better consumer experience, lower costs, and improved outcomes.

Three listening sessions attended by one hundred and twenty eight stakeholders were held in early September 2011. The purpose of these sessions were to receive participants' insights on how Maryland can capitalize on health reform to create a better integrated system of care. These listening sessions focused on four questions:

- What would an integrated system in Maryland look like in terms of practice, delivery platform, benefits management, and financing?
- How could Maryland move to an integrated system?
- What are the features of the current system that support integration?
- What are the opportunities for improvement in the current system in terms of integration, patient-centered care, and health and wellness?

Two additional stakeholder meetings were held in mid-November in Annapolis and Frederick, at the request of stakeholders, to give input on the options being considered by the consultants. Approximately 80 stakeholders attended these two meetings.

The Consultant Report provides an assessment of the strengths and weaknesses of Maryland's behavioral health care system. The report confirms that Maryland invests considerable resources in behavioral health care, and thousands of citizens benefit from high quality, compassionate, and evidence-based care each year. However, the report also noted that our current system largely pays on the basis of the volume of services rather than measurable health outcomes such as recovery and reductions in avoidable hospitalizations, other outcomes such as employment and reductions in homelessness, cost-effectiveness, or overall value. The report made the following observations about Maryland's current system:

- Benefit design and management are poorly aligned;
- Purchasing and financing are fragmented;
- Care management is not coordinated;
- Performance and risk are lacking; and,
- Integrated care needs improvement.

The report details a number of innovative integration efforts underway nationwide that could be replicable in Maryland. Looking to 2014, when the full implementation of health reform will precipitate a range of changes in state health care (including the transition of the Primary Adult Care program into a full-benefit Medicaid program), the report proposes two alternative models for moving forward:

- Option 1 is described as a “protected carve-in.” Under this model, Maryland would bundle funding for medical care, mental health and substance abuse in the HealthChoice program. The carve-in of behavioral health services would be “protected” because the model would ensure adequate and identifiable funding for behavioral health services. The Consultant favored this approach on the grounds that the establishment of a responsible organization for each individual would provide a powerful incentive for integrated care and prevention. There remain, however, important questions about the readiness of managed care entities to truly integrate care and incentives. Often, a traditional managed care entity simply subcontracts the provision of behavioral health services to another entity, creating siloed systems not unlike Maryland’s currently fragmented system.
- Option 2 is described as a “risk-bearing carve out.” Under this model, Maryland would hire an organization to manage behavioral health benefits (both substance abuse and mental health) under some form of performance and/or financial risk model, and this entity would coordinate the services for which it has responsibility with the physical health benefits now managed by the MCOs in the HealthChoice program. The consultant disfavored this approach on the grounds that, while it would improve the coordination between mental health services and substance abuse services, and while it would create a model focused on outcomes and value, it nevertheless would fail to integrate behavioral health and medical care, and it would fail to align incentives for better outcomes across both behavioral health and medical care.

Principles for Integration

Following the publication of the Consultant Report, seven principles were developed by Secretary Sharfstein and the Department to guide the next steps forward choosing a specific integration strategy:

1. A new system should provide the greatest value to Maryland consumers. Individuals and families should be able to access the right services at the right time to remain as healthy and productive as possible.
2. A new system should support effective models of integrated care. These models include health homes, where medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan for the whole person.
3. A new system should prioritize the needs of the seriously ill. Special attention must be paid to assure coordinated care for especially vulnerable Marylanders who experience severe mental illness or substance abuse disorders.
4. A new system should integrate financing for substance abuse and mental health treatment services. Given the high degree of comorbidity, our financing system should not fracture along the lines of diagnoses within behavioral health.
5. A new system should provide payment on the basis of performance, value and outcome, and not just volume. Such payment reform transformations are occurring throughout the health care financing and delivery systems for all payers and services, and the behavioral health system must join this movement to align incentives with prevention and health for Marylanders.
6. A new system should include a strong role for local oversight and engagement. The financing system should provide comprehensive service and outcome data to localities. Currently, localities receive only a fraction of important data about the care of their residents. More full information will allow for the identification of unmet needs and the design of programs to address them.

7. A new system should be able to coordinate well with other systems, including the criminal justice, education, and child welfare systems, to promote social outcomes such as successful community reintegration, adoptions and permanent placements, school achievement, and others.

Recommending a Model

In early 2012, the Department established a Steering Committee led by the Deputy Secretary for Health Care Financing to review the financing and integration options. Membership included representatives from all key programmatic units at the Department (see Appendix III for complete Steering Committee membership).

Between March and September 2012, the Department held a series of large public stakeholder meetings to inform the selection of a financing model. The Steering Committee developed three documents, which were circulated for public comment and finalized as the first charge of this stakeholder process. The Department used these documents to guide the rest of the process. Building on work done to date, the first document described three proposed finance and integration models (two of which were outlined in the Consultant Report, and a third added by the Steering Committee) (see Appendix VI). The second document presented eleven criteria for stakeholders and the Steering Committee to use when evaluating the three models, such as ensuring delivery of the right service, in the right place, at the right time, by the right practitioner (see Appendix VII). The third document charged four workgroups with the task of addressing specific issues related to the selection of a financing model, augmenting the large public stakeholder meetings (see Appendix IX).

The Department developed an email list that ultimately included 831 individuals, and all materials, meeting announcements, and resources were distributed through this list. The Department accepted comments, both in writing and in twenty-four public meetings from May through September 2012, and the Department used a webinar approach for all these meetings to allow individuals to participate across the State without needing to attend in-person. Issues and discussions that arose in each workgroup were used to inform the large public stakeholder meetings, and the Steering Committee compiled reports from each workgroup to inform the Committee's final decision regarding model selection. These workgroup reports are available as Appendices XI-XIV.

This report and the final recommendation are the culmination of all behavioral health integration efforts since 2011. The Steering Committee would like to thank its members, the Consultant, stakeholders, and all other contributors for their invaluable input to this process.

Model 1: Protected Carve-In (Recommended in Consultant Report)

Medicaid-financed behavioral health benefits would be managed by Medicaid managed care organizations (MCOs) through a “protected carve-in”. The MCOs would be responsible for managing a comprehensive benefit package of general medical and behavioral services. MCOs would receive a separate, dedicated behavioral health capitation payment that only could be spent on behavioral health treatment and recovery supports. Any savings related to behavioral health services would be re-directed to additional, innovative behavioral health benefits. Contractual conditions would require the MCOs to employ specific behavioral health practitioners in clinical leadership positions, would specify the credentials of staff who performed behavioral health utilization management, and would put the MCOs at risk for demonstrating that they were assuring access to the behavioral health benefit. This model would protect funds spent on behavioral health treatment but would allow the MCOs to have flexibility in how they structured care coordination, utilization management, etc. Contractual conditions would require uniform processes for providers (e.g. claims payment, credentialing) and streamlined administrative systems. Specific behavioral health performance standards would allow the State to evaluate access, adequacy of the provider network, treatment quality, and outcomes for cohorts of enrollees, e.g. adults with serious mental illness, youth with complex needs, etc.

Under Model 1, an MCO could manage behavioral health care in one of three possible ways. The first would be to fully integrate behavioral health into its current structure without subcontracting to a behavioral health organization (BHO). The second option would allow MCOs to subcontract with a BHO of their choice. The third would select a statewide BHO with whom all MCOs must subcontract for behavioral health services.

One of the advantages of integration in Model 1 is that health care overall should improve as consumers receive the whole body care they need. As a result, the health care system should see cost savings on the somatic side as a result of improved behavioral health treatment, and vice versa. A strong advantage of Model 1 is that having one entity responsible for both somatic and behavioral health care ensures savings are retained and able to be reinvested in the right system. In other words, an MCO might have an incentive to invest in preventive behavioral health services because these costs might reduce the MCO’s costs related to emergency room visits and hospital admissions. Thus, Model 1 would avoid a potentially complex cost allocation methodology would not be necessary to distribute savings to the appropriate entity.

Another advantage to this model would be continuity for consumers. As individuals’ health care needs or the needs of their family members change, under another model they could be forced to switch entities, such as from MCOs to a managed behavioral health organization under Model 2. Further, the definitions of “behavioral health need” and “severe behavioral health need” will continue to change over time. This could affect the criteria to be eligible for a specialized entity under Models 2 or 3, such that individuals become ineligible to have their care managed by the specialized entity simply due to a change in definitions. A reality of any model other than a fully integrated model is ongoing administrative activity around these changes. Under Model 1, as health care needs and definitions change, individuals will always have their care managed by the same entity.

Under a fully integrated model, there is no potential for adverse selection between entities. No matter a person’s health status, the same entity is responsible for his/her care. This could have many benefits, including: (1) keeping costs down by preventing adverse selection among entities; (2) maintaining

accuracy in data (as providers are concerned with different diagnoses being reimbursed differently); and (3) better whole body care across the lifespan.

Most of the disadvantages of Model 1 are linked to one of the three potential ways an MCO could manage behavioral health care. There is a significant amount of fear among stakeholders regarding MCOs' current practices. If the MCO were to fully integrate behavioral health into its current structure and not subcontract to a BHO, stakeholders would insist on realigning incentives, additional quality controls, and a cultural shift from illness treatment and preventing recurrence to early identification and prevention.

Another significant concern regarding the way MCOs currently operate involves data collection. At present, collecting data from MCOs is seen at present as neither timely nor transparent due to the fact that there are multiple MCOs, each with their own systems and regulations.

Stakeholders were also apprehensive about this option because of the uniqueness of the behavioral health population. MCOs do not have experience serving people with serious and persistent behavioral health needs, such as providing psychiatric rehabilitative services or mobile treatment, and this may have negative consequences for consumers. In addition to services, the outreach and education, incentives structure, provider qualifications, etc. may all be different for the behavioral health population than for the general population. Contributors expressed that MCOs may not be able to give this population the attention they need, especially in the first few years. If this option is selected, the specifications outlined in Phase 3 would be particularly important to be sure the system strengthens its current weaknesses.

Allowing MCOs to subcontract with a BHO of their choice may alleviate some of the concerns around the current MCO system. However, providers may be frustrated by the potential "end result" working with up to seven MCOs and seven BHOs with seven different claims, credentialing, and authorization systems. In addition, this could result in seven different provider networks for somatic care and seven additional provider networks for behavioral health care, which could be very complicated for the behavioral health population. It is possible that the State could streamline these systems, and this should be considered if this option is recommended.

If the State selected a single BHO with which MCOs must contract for behavioral health services, it may alleviate many of the above concerns. However, it may not be preferable to MCOs to be told who to do business with, and the BHO may not work well with each of the seven different entities.

Conceptually, stakeholders supported a fully integrated model like Model 1. Realistically, however, most did not believe the current system would be capable of a successful transition to this model.

Model 2: Risk-Based Service Carve-Out (Presented in Consultant Report)

Medicaid-financed specialty behavioral health benefits and the State/block grant-funded benefit package would be managed through a risk-based contract with one or more Behavioral Health Organizations (BHO). Using a competitive selection process, Medicaid would contract with one or more BHO(s) that would bear insurance and/or performance risk. Contractual conditions would be aligned with those of the Medicaid MCOs; performance standards would be robust; and performance risk would be shared with MCOs for continued implementation of health homes for persons with behavioral health conditions, as well as health homes for persons with chronic medical conditions and for improvement in health outcomes for persons enrolled in health homes. The services delivered through the BHO(s) would be specialty behavioral health services. MCOs would continue to provide specified behavioral health care typically associated with primary care providers.

Under this model, a specialized entity would be responsible behavioral health benefits, separate from the entity(ies) responsible for somatic care (MCOs). There could be one or multiple specialized entities; this entity(ies) could take on either insurance risk or performance risk. In other words, there could be one or more managed behavioral health organizations (MBHOs) or one or more administrative service organizations (ASOs) managing behavioral health services for the total population.

Most stakeholders supported a single MBHO/ASO under Model 2. Contributors pointed out that having more than one MBHO/ASO could be very complicated and burdensome for consumers and providers. Like Model 1 in the case where each MCO could subcontract with the BHO of their choice, Model 2 with multiple MBHO/ASOs could mean providers having to deal with two or more entities on the behavioral health side in addition to the seven MCOs. As provider qualifications, contracting standards, covered benefits, financing structures, and others could all vary by entity, this could get very complicated and administratively burdensome for providers. A single MBHO/ASO with a closed provider network may limit consumer choice of providers and, thereby, limit access. However, multiple MBHO/ASOs could also be complex for consumers who may potentially have to change MBHO/ASOs when they change MCOs, which may mean navigating a new provider network, different covered services, etc.

An advantage to a specialized entity managing all behavioral health services for the total population (as opposed to an entity managing all services) could be that this entity has the tools, experience, and focus to best manage care for these services specifically. Unlike under Model 1, an MBHO/ASO would likely have experience providing specialty behavioral health services. They may also be better equipped to conduct outreach and education, provide customer service, design provider incentives, manage funds, and offer services in a way that is most beneficial to the population, compared to an entity also managing somatic care.

Model 2 in particular could allow consumers to get the care they need, as non-Medicaid services could be supplemented with grant-funded services (with all funds managed by the MBHO/ASO). An ASO in particular may result in better access without an over-emphasis on controlling costs, as there wouldn't be a cap on behavioral health dollars as there would be under a MBHO or MCO model.

A single MBHO/ASO could allow for richer data and measures on a population level because the MBHO/ASO would focus solely on the behavioral health population (and would focus on the entire population who receive behavioral health services, unlike a specialized entity under Model 3). Data may be more streamlined and timely under this model than under the other two models.

Behavioral health providers may benefit from a single MBHO/ASO managing all behavioral health services as opposed to MCOs under Model 1, as a single MBHO/ASO may increase the efficiency with which providers are credentialed or form partnerships to effectively deliver the services. For instance, it may be easier to coordinate Medicaid services with grant-funded behavioral health services if the MBHO/ASO has a relationship with non-Medicaid systems. In this way, the behavioral health population may also benefit from this model. In addition, working with a single MBHO/ASO may be less administratively burdensome for providers and for the State, who would only have to modify a single contract to respond to payment and clinical delivery innovations and monitor one entity for quality and compliance with contract standards. However, this model may make it difficult to keep up with changing definitions of primary and specialty care as well as changing service delivery systems, which may require repeated contract modifications or re-procurement.

A potential challenge under Model 2 would be the link between somatic and behavioral health care data for each individual. Separate data sources may make it easier to track performance and utilization data for behavioral health-specific issues. However, since consumers would still be receiving their somatic services through an MCO, the MCOs and the MBHO/ASO would need to coordinate so that data on the whole person is available to all entities and providers for the purpose of assessing clinical outcomes.

An appropriate cost allocation methodology would need to be established between the MBHO/ASO and the MCOs so that savings on either side due to improved outcomes would be seen by the appropriate entity. This may be a significant challenge, as there may be disputes over which entity is entitled to certain savings, as well as which entity is responsible for pre-authorizations and payments. Stakeholders were concerned that misalignment may reduce incentives for an MBHO/ASO to invest in certain interventions that create savings on the somatic side, particularly if the cost allocation is not done sufficiently. Separate entities may, however, make it easier to identify provider integrity or cost issues that are clearly on either the somatic or behavioral health side.

Early identification and prevention was noted as a potential challenge under Model 1 due to the current focus on treating illnesses and preventing recurrence. There are also concerns about early identification and prevention under Model 2, but for a different reason. While a specialized entity may have the expertise for and resources to dedicate to early identification and prevention, it may be more difficult because individuals are receiving their somatic treatment through another entity. Individuals do not enter the MBHO/ASO until they require behavioral health services. As a result, coordination between the MBHO/ASO and MCOs would be critical to identify and prevent behavioral health issues.

One of the biggest challenges stakeholders see under this model is the coordination of care for an individual for their somatic and behavioral health needs. Individuals with concomitant health conditions will be treated in two different systems. While this may result in better health outcomes because the different systems have more focused expertise, it may also lead to poorer health outcomes as consumers and their families navigate two systems of care. Similarly, it may be difficult to quantify consumer engagement across two systems of care as somatic and behavioral health interact through the lifespan.

The majority of contributors supported Model 2 on the grounds that it would best retain the strengths of the current system (such as current linkages with the child welfare and juvenile justice systems) while adding significant value (like value-based cost containment).

Model 3: Risk-Based Population Carve-Out (Newly Introduced in this Process)

As in Model 1, all Medicaid-financed behavioral health benefits and general somatic benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty managed care entity (SMCE) to manage the comprehensive benefit package for individuals with serious behavioral health disorders. That is, enrollment in the specialty health plan would be determined by whether the individual has a specified behavioral health diagnosis, such as serious and persistent mental illness. If such a diagnosis is present, the person would be enrolled in a specialty health plan, which would be required to deliver the full array of behavioral health and medical benefits. If such a diagnosis is not present, the person would be enrolled in a traditional MCO to receive his/her full array of behavioral health and general medical benefits.

Model 3 shares many of the benefits and challenges of Model 1, as the models are closely tied to one another. Under Model 3, all Medicaid-financed somatic and behavioral health services are provided under a SMCE for a specific population. Individuals who do not fit the criteria to have their services covered under the specialized entity will receive all services through MCOs, including behavioral health services. Instead of repeating the discussions that took place around Model 1, readers should keep those in mind as they read these additional points specifically regarding a SMCE.

Individuals with serious behavioral health needs may benefit significantly under Model 3. As the SMCE would focus on this population specifically, the delivery of services for this population may be more integrated and tailored to their unique needs. A specialized entity may be better at engaging consumers regarding their whole body health, and consumers may be more likely to access and follow-up with care, leading to better outcomes. Depending on the specifications, individuals may have access to continuous care over their lifetime, which could also drastically improve outcomes for this population.

The SMCE may find it easier to tailor performance targets for providers dealing with higher-need consumers, as opposed to an entity managing care across the continuum of need. In addition, a specialized entity for this population may mean more timely adjudication of claims and authorization data.

Early identification and prevention may be a challenge under Model 3, as individuals must be diagnosed with a high behavioral health need in order to have their services managed by the SMCE. Coordination between the SMCE and the MCOs would be necessary to ensure appropriate early identification and prevention.

Under Model 3, there is the potential for adverse selection as providers may be incented to diagnose consumers with moderate needs as consumers with severe needs to move them from the MCO into the SMCE (or vice versa). Similarly, there may be disincentives for patient recovery (or for the documentation of improved outcomes) from the SMCE in order to retain consumers. Such mis-labeling could harm consumers and significantly skew data on this population.

Churning between the SMCE and MCOs is a concern as consumers fluctuate on the behavioral health status continuum over their lifetime. If this model is adopted, individuals should be allowed to remain in the SMCE for a period of time (potentially for their lifetime) to enhance continuity of care. If the individuals transition between entities, there will need to be a high level of coordination because there will be two sets of somatic and behavioral health data for each person. Family continuity may be an

issue under this model if some family members receive care through MCOs and others through the SMCE. While this model may be administratively efficient for the population with high behavioral health needs, these efficiencies may be lost if individual and/or family continuity is poor.

Stigma may be an issue under this model, as high-need consumers would be receiving care from a different entity. However, health plans providing care to the high-need behavioral health population could engage with consumer advocates to minimize any stigma that may be created by participating in the SMCE.

A specialized delivery system may be more adaptable to emerging innovative clinical practices as they have a smaller, more well-defined population for which to provide services. However, to ensure financial viability, payment rates would have to be carefully evaluated and reevaluated as the population included in the specialty group is redefined or churns into and out of the system.

Some concern was expressed for this Model from a budgetary standpoint. Though savings are anticipated on the somatic side for the adult population, they may be hard to demonstrate and are not expected for the child population. As an expensive program, as well as a program serving people very different from the general population, stakeholders raised the question of whether this program would survive budget cuts. It was pointed out that this model may be the best way to demonstrate cost-savings for this population and may, therefore, be the safest place for the care of high-need individuals.

The majority of stakeholders supported the concept of a population carve-out as it applied to a health home model, but did not support this model as the new, statewide financing mechanism for Medicaid behavioral health services.

Recommendation

After considering all input through the numerous public meetings and written comments, and after comparing all three models against the eleven criteria and seven guiding principles, the Steering Committee recommends Model 2, a behavioral health organization (BHO) carve-out. The discussion about the form of “risk” this entity would assume is found below.

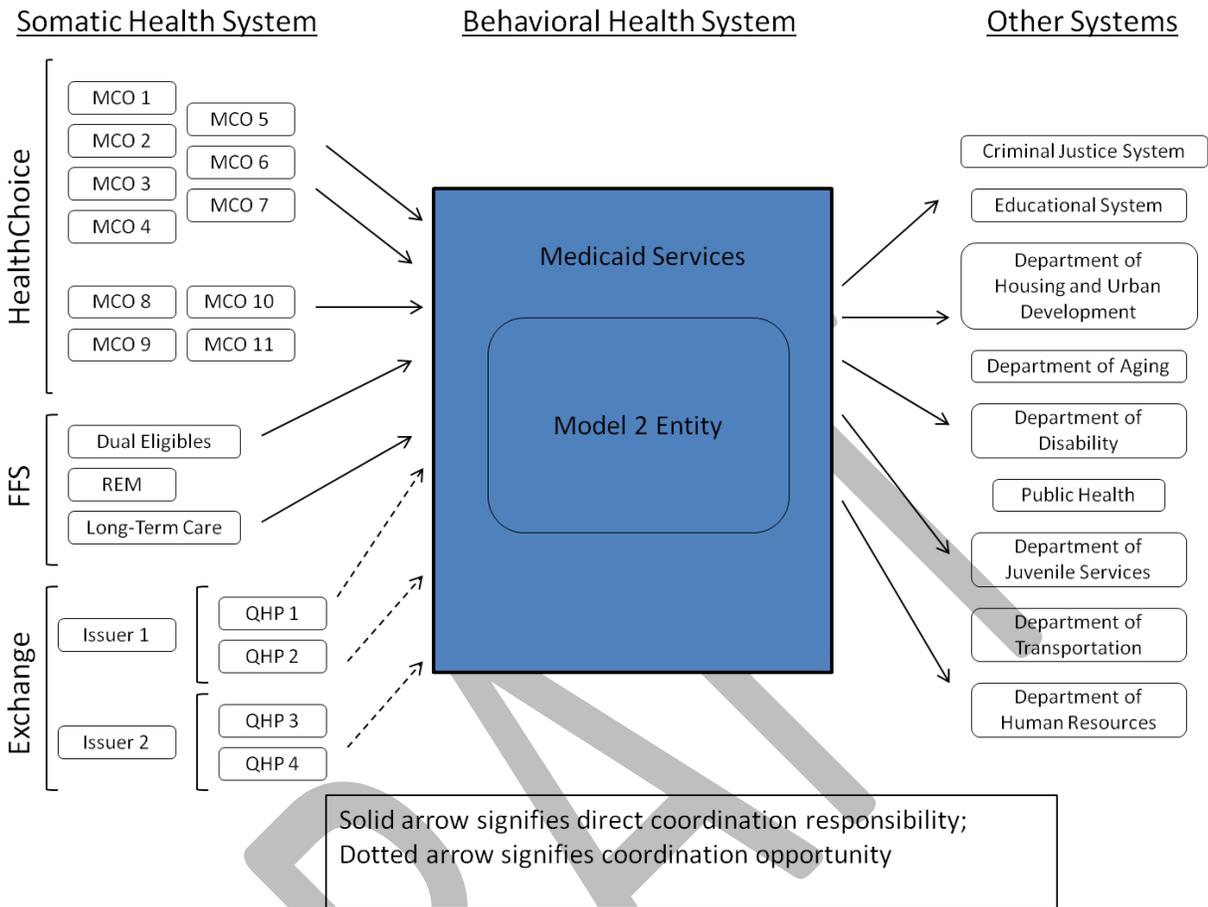
The basis for the recommendation follows:

1. Model 2: Behavioral Health Organization Carve-Out

Model 2 offers important advantages over the other models.

- Covers All Medicaid Eligibles. Only Model 2 reaches all current Medicaid beneficiaries – including HealthChoice enrollees, Medicare-Medicaid dual eligibles, individuals in REM, and those individuals in long-term care who are not dual eligibles. Because 20 percent of the individuals enrolled in Medicaid who have a behavioral health diagnosis are not members of MCOs, both Model 1 and Model 3 would fail to reach all Medicaid beneficiaries.
- Reduce Burden on Providers. Currently, there are seven HealthChoice MCOs, with four additional MCO applicants seeking to enter the HealthChoice program by January 2014. In Model 1 or Model 3, each of these MCOs could establish its own standards (directly, or through a subcontracted BHO) regarding behavioral health provider credentialing, prior authorization, utilization review, payment rates, and contracting practices. All of these MCO-developed policies and procedures would create substantial administrative costs and burdens for behavioral health providers, and would direct financing away from care and toward administration. On the other hand, if Model 1 or Model 3 was selected, and the Department sought to reduce this administrative burden by requiring each MCO to use the same BHO (which would be a BHO independently selected by the Department), we would have a structure that is virtually identical to Model 2 anyway.
- Adaptable when Somatic Programs Change. On the somatic side, Medicaid is likely to see changes in the future, as new MCOs join HealthChoice (and as MCOs’ service areas periodically change), and also as Medicaid eventually pursues one or more initiatives to integrate care for Medicaid-Medicare dual eligibles. Model 2 would allow Medicaid to pursue these changes without continuously changing the structure for the delivery of behavioral health benefits. This is depicted on the left-hand side of Illustration 1 below, whereby each MCO or fee-for-service program could link to the Model 2 entity.

Illustration 1



- Adaptable when demographic factors change.** One of the trends expected in the next several years is an increase in the rate at which individuals will shift from “Medicaid-only” status to Medicaid-Medicare dual eligible status as more Medicaid eligibles turn 65 (along with the rest of the baby boom wave). Dual eligibles in Medicaid do not receive somatic services through MCOs but, rather, FFS. This means that many individuals “age out” of managed care when they turn 65. Under Models 1 or 3, people would be forced to leave their MCO-delivered behavioral health system and provider when they are required to disenroll from their MCO upon becoming eligible for Medicare and converting into dual eligible status. Model 2 would eliminate this transition, and allow an individual to stay with his/her BHO to access behavioral health services after he/she turns 65 and becomes a dual eligible.
- Relationship to Non-Medical Systems.** Individuals with significant behavioral health needs often are involved in many non-medical systems, including schools, housing, employment, criminal justice, and others. A single contract with a Model 2 entity would create a single point of accountability and coordination to link Medicaid-financing behavioral health services with these other agencies, programs, and services. In other words, Model 2 best integrates the Medicaid-financed behavioral health benefits in treatment for mental illness and substance use disorders with other systems in which consumers frequently are involved. Both Model 1 and Model 3 would create countless

points of contact, communication, and coordination between behavioral health medical care and these other systems, and would diminish integration across systems. This is illustrated on the right-hand side of Illustration 1, above.

- Eligibility “Churn”. The data workgroup was presented with information that 44 percent of the individuals in Medicaid who have a behavioral health diagnosis are individuals in Medicaid’s poverty-related family and children’s eligibility categories. Put differently, even though these individuals require specialty mental health services, they are not eligible for Medicaid by virtue of disability, but rather are eligible for Medicaid by virtue of poverty. A report published in Health Affairs in 2011 estimated that approximately 35 percent of adults with incomes below 200 percent of the FPL will experience a change in income that causes them to move above or below 138 percent of the FPL (i.e. causes churn between Medicaid and the Exchange) within six months, 50 percent within a year². This is relevant to the behavioral health integration recommendation because Model 2 best coordinates the transition of individuals between Medicaid and Exchange-offered qualified health plans (QHPs) as a single point of transition for specialty mental health services. Models 1 and 3 would require many additional points of contact for these transitions. This is also depicted on Illustration 1.
- Relationship to Exchange (In Addition to Churn). The Exchange will be offering QHPs from commercial insurance carriers. QHPs must deliver “essential health benefits”, which will include an array of behavioral health benefits, offered in compliance with mental health parity laws. Model 2, with a single BHO, will best facilitate the transition of care when individuals move between Medicaid-financed behavioral health (and the substantial Medicaid benefit package for treatment of mental illness and substance use disorders), and QHP-offered behavioral health. These transitions will arise not only when household income changes, but also when children in households between 138 – 300 percent FPL age-out of Medicaid and CHIP eligibility and become adults, thereby moving from Medicaid to the Exchange.³ A single BHO is likely to facilitate these transitions of care into and out of the Exchange’s QHPs more smoothly, especially as the scope of the covered benefits shrinks (when people move from Medicaid to the essential health benefits) or expands (as people move from the Exchange into Medicaid).
- Relationship to Other Forms of Commercial Insurance. A BHO with responsibility for all specialty behavioral health in Medicaid might be an attractive entity for contractual relationships with commercial insurance carriers, in order to deliver any behavioral health benefits in the Exchange.

2. Insurance Risk

² Sommers, Benjamin D. and Sara Rosenbaum. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. Health Affairs. February 2011. vol. 30 no. 2 228-236.

³ Beginning in January 2014, children in foster care will be allowed to stay in Medicaid until they turn 26, under an optional provision of the ACA that Maryland will implement.

The Department's Steering Committee supports the version of Model 2 that includes insurance-risk (capitated managed care), performance risk, and payment reform. The Department supports this version of Model 2 for the reasons mentioned here:

- Benefit flexibility. A capitated program would allow much greater flexibility around benefits, because a capitated BHO would not be required to stay within the confines of the approved benefits in the Medicaid state plan. For example, a capitated BHO could utilize its rates to finance educational programs, mentoring programs, peer support programs, music and vocational services, and other more nimble benefits.
- Flexible Payment Methods. Unlike a system that is built on ASO model (which would utilize only those payment rates and methods in Medicaid FFS), a capitated BHO could pay different rates for the same service rate based on a provider's performance, volume, and other factors. In addition, a capitated BHO could enter nimble gainsharing (shared savings and shared bonus) arrangements with providers, as well as subcapitation and other flexible payment methods.
- Direct Relationship with Providers. Unlike an ASO, which has no direct relationship with providers, a capitated BHO would have direct contractual relationships with behavioral health providers. This would enable a capitated BHO to utilize tools to improve quality and efficiency, such as: (a) exempting "good" providers from certain authorization requirements ("good" defined to mean delivering care using evidence-based practices in the most appropriate setting); (b) terminating the contracts of "bad" providers; and (c) developing provider-specific scorecards (detailing) to improve providers' practice patterns.

The major issue to address, before this report is finalized, is whether Medicaid-financed behavioral health services are ready to be transitioned to the version of Model 2 that includes insurance-risk (capitation) as the next step, or whether this needs to be achieved incrementally after first moving through a stage that would involve transitioning all specialty behavioral health services to a Model 2 carve-out on a non-insurance risk (performance risk) based version of Model 2.

Moving to a capitated model could not be accomplished until, at the earliest, January 2015. This timeline is dictated by the need to first pass enabling legislation, and then to conduct the necessary procurement and to secure the necessary federal Medicaid waiver.

Moving through an incremental stage first, involving a non-capitated form of BHO, could occur sooner, such as January 1 (or July 1), 2014. This earlier timeline is achievable because enabling legislation is not necessary.

3. Application of Criteria

Eleven criteria were established at the beginning of this process to guide the selection of a financing model (these criteria can be found as Appendix VII to this report). The advantages that have been put forth in this report demonstrate that Model 2 best ensures the fulfillment of these criteria.

The reduced burden on providers, in combination with flexibility around financing and benefit design, would ensure the right providers are accessible in the right place at the right time, and that the right

services are provided. In addition, an entity solely responsible for behavioral health services would be in the best position to design authorization requirements, incentives, and other mechanisms that best fit the abilities of behavioral health providers and meet the needs of the behavioral health population. For this reason, Model 2 would also best ensure positive health outcomes specifically in behavioral health, in particular for those individuals with chronic behavioral health conditions. This model may present challenges on the somatic side, which are addressed later in this report. A single entity managing care for all behavioral health services may allow for richer data and measures to be collected and accessed quicker and easier than under either Models 1 or 3.

A single entity, focused solely on behavioral health with established relationships with behavioral health providers as well as non-medical systems would be in the best position to ensure preventive care, including early identification and treatment. An entity with such established expertise and relationships is also in the best position to engage behavioral health consumers and deliver evidence-based services in a culturally and linguistically competent way.

Housing all behavioral health services for all people under a single entity, an entity that could possibly provide services for Medicaid beneficiaries, dual eligibles, Exchange enrollees, and commercial insurance consumers alike, would best ensure care across the lifespan and as individuals' needs and program eligibility changes. It would also best ensure that the system is adaptable over time, as the BHO would have significant flexibility and would be impervious to changes that may occur on the somatic side. This may also reduce administrative burden and make providing behavioral health services more cost effective than a system under which multiple entities manage and finance these and other services.

4. Review of Integration Principles

In his cover letter to the 2011 Consultant Report, Secretary Sharfstein outlined seven principles to guide future integration work. The Steering Committee is convinced that the advantages that have been put forth in this report demonstrate that Model 2 best upholds these principles.

All of the models being considered during this process integrate financing for substance abuse and mental health treatment services. By ensuring delivery of the right services in the right place and time by the right practitioner, Model 2 would provide the greatest value to Marylanders. It would also support effective models of integrated care and be able to coordinate with other systems through strong, established linkages with non-medical systems and by caring for individuals across their lifespan and as needs and program eligibility changes.

An entity solely focused on behavioral health services, with demonstrated expertise with this population, would be able to best care for the needs of the seriously ill. A capitated entity would have the flexibility to provide payment on the basis of performance, value, and outcomes, and would have the direct relationships with providers necessary to ensure strong oversight and engagement. The data collected would likely be more comprehensive, timely, and accessible than it would have been under either Models 1 or 3 and, thus, would be very helpful to localities when caring for their residents.

5. Challenges in Model 2

Clearly, Model 2 is not perfect. Model 1 and Model 3 offered advantages that do not exist in Model 2, and addressing the limitations and challenges in Model 2 will be a crucial element in the next phase of this effort. These challenges that must be addressed include:

- Care coordination. One of the major challenges with Model 2 involves the lack of direct integration between somatic care (including primary care) and behavioral health treatment. The Department will need to address this, potentially by formalizing care coordination between the BHO and MCOs in structural ways that do not exist under the current mental health ASO arrangement. For example, a possible model is found in Michigan, where both MCOs and the BHO are required to formally support care coordination, and to create a “care bridge” (in the language of Michigan).
- Incentives. Because the entity managing behavioral health services under Model 2 would not be at risk for somatic outcomes or expenses, the BHO would not be financially incented to provide preventive behavioral health services that reduce somatic expenses, such as hospital emergency room visits and inpatient admissions. This is not a trivial matter: the Department presented information to the data workgroup that 87.8% of all emergency room visits for Medicaid beneficiaries with a behavioral health diagnosis were to address a somatic complaint. Given this challenge, the Department will need to develop and monitor data to promote rate setting approaches (potentially including gainsharing across HealthChoice and the Model 2 BHO) to incentivize the delivery of preventive behavioral health services that drive down avoidable emergency room visits and inpatient admissions.
- Payment disputes. Adopting Model 2 would require developing an approach to address billing disputes between, on the one hand, the BHO and, on the other hand, MCOs. For example, Maryland’s hospital payment system requires that a single entity pay an entire hospital bill – the Health Services Cost Review Commission (HSCRC), which regulates hospital payments, prohibits so-called “split billing” whereby a single bill is split across different payers. As a result, payment disputes are likely to arise between the BHO and MCOs when, for example, an individual enters a hospital with one presenting diagnosis or chief complaint, but after testing and evaluation, another cause or diagnosis for the hospital encounter is identified.
- Defining services. Adopting Model 2 also will require the Department to define which services are the responsibility of the BHO, and which are the responsibility of the MCOs (for individuals enrolled in HealthChoice). Model 2 might require the Department to periodically revisit this allocation over time to determine which delivery system should be accountable for which services as new treatment modalities (and forms of bundled payments and medical home initiatives) emerge in the market.

Next Steps

Despite the great work that has been done thus far, the process is far from over. Over the next few months, the Secretary and the Legislature will review this recommendation, and discussions will continue between the Department and the stakeholder community. The next phase of this process will involve developing specifications for the new system, which the Department has described as Phase 3 of this integration effort. While selecting the right model for the state was a critical step in the process, the specifications will drive the success of the integration efforts. Specifications could include issues such as:

- Authorization/utilization rules. Establishing prior authorization rules, and/or utilization review rules, is independent of the model. For example, and for illustration purposes only, regardless of the model the State could contractually specify that (a) some services should be exempt from prior authorization (i.e., the beneficiary can self-refer), (b) outpatient therapy counseling should be initially approved in an amount not less than ten visits, or (c) all residential and inpatient stays must receive prior authorization. In a well-managed system, perhaps some providers with high quality scores should be exempt from certain authorization rules, while providers that are new and/or lower quality should continue to have more oversight. These requirements are needed.
- Medical-Loss Ration and Margins. In a capitated form of Model 2, the Department will need to ensure that the capitation payments end up in care and services, rather than in profit margins and denials of access. The Department will need to structure these requirements.
- Gainsharing. Gainsharing involves the rules by which savings are shared across entities (such as a BHO and MCOs) and providers to align savings and promote good care and practices. In Phase 3, the Department will need established methods to promote and evaluate gainsharing.
- Quality measures and reports (that could also involve performance incentives/sanctions). Identifying what measures the state should focus on when conducting contractual oversight is independent of the model. Potential measures could include beneficiary and provider satisfaction, access/utilization rates, HEDIS scores, unnecessary readmission rates, and others. Determining the measures, setting relative financial weights (values) for each measure, and determining what portion of the overall financing to place in bonuses/sanctions are elements that are independent of the model.
- Any willing provider. Does the BHO have the right to exclude any provider, or must the BHO contract with “any willing provider”? Allowing the BHO to selectively credential and contract with behavioral health providers might result in higher quality (by excluding low-performing providers), and it might result in greater cost efficiencies (by contracting at rates based on scale and volume). On the other hand, excluding certain historic or potentially essential providers might narrow consumer options and limit access.
- Provider rates. While the ASO model would simply utilize Medicaid’s FFS rates as the payment system, the rate structure in any capitated BHO model could be established by specifications that could reflect better incentives and provider capabilities (e.g., a provider’s ability to manage a global budget or subcapitation for an array of services).
- Beneficiary protections. Certain kinds of beneficiary protections could be specified. For example, the state could compel any entity, even an ASO, to organize a beneficiary “advisory council”, a beneficiary “Ombudsman”, and similar requirements. Additional protections, regarding issues like a guaranteed right to a second opinion in certain circumstances, the operation of a 24/7

beneficiary call center, and an “expedited” grievance and appeals system also could be required in any model.

- Staffing requirements. The state could specify the credentials for the BHO’s professionals in its clinical leadership positions, such as the credentials of staff who perform behavioral health utilization management.

The Department hopes stakeholders will remain engaged to help ensure that integration is affordable and practicable for providers, cost-effective and manageable for payers, and most importantly, improves outcomes, lower costs, and creates a better consumer experience for all Marylanders.

DRAFT