Recommending an Integration Model for Medicaid-Financed Behavioral Health Services

Department of Health and Mental Hygiene
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Introduction

This report is the accumulation of efforts put forth regarding the integration of Medicaid-financed behavioral health in Maryland. The recommendation of a financing model for behavioral health services presented in this report model represents the completion of Phase 2 in a three-phase process. Significant work lies ahead of us as we present the recommendation to the Legislature and develop the specifications around the model selected to ensure this model is the best choice for all Marylanders. We greatly appreciate the contributions of everyone who has participated thus far and look forward to continuing to work with you to improve behavioral health in Maryland.

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Executive Summary

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Background

Consultant Work in 2012

Overview of the Current System

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.[i]" The Substance Abuse and Mental Health Services Administration 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 diagnosis have significant chronic, somatic health conditions such as diabetes or health disease. These conditions are largely responsible for a 25-year gap in life expectancy between those with serious behavioral health disorders and those in other populations.

While many Marylanders suffer from mental illness, chronic health conditions, and substance abuse, the financing system that services them is fractured:

- There is one path to access medical treatment and some behavioral health services in primary care, through Medicaid;
- There is a second path to access addiction services, through local jurisdictional grants; and,
- There is a third path for specialized mental health care, through the Mental Hygiene Administration's fee-for-service program.

These disparate paths rarely meet to provide coordinated care for patients. The combined cost of medical, substance abuse treatment, and mental health care for high-cost individuals can reach hundred of thousands of dollars per patient per year. Our system should spend funding strategically to improve outcomes and lower costs.

Health Care Reform and Behavioral Health

Many private insurance options do not currently cover behavioral health services. Low-income individuals who rely on publically-funded services must navigate a fractured system, as described previously. Many low-income individuals are not eligible for Medicaid for reasons such as they make too much money or do not have children. Health care reform will change the way individuals with behavioral health care needs access services.

Beginning in 2014, most individuals under 138% of the federal poverty line (FPL) will be eligible for Medicaid under Medicaid Expansion. In addition, all health plans will be required to cover behavioral health services. This will mean that the need for grant-funded services will decrease as private and public insurance take its place. As a result of all of these changes under health care reform, Medicaid is going to be the predominant avenue to behavioral health services for individuals below 138% FPL.

The Integration Process

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As part of the FY 2012 budget, the 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 lack of coherence in Maryland's approach to patients with behavioral health conditions.

The Department worked with stakeholders and engaged a consultant to examine options for the integration of Medicaid-financed behavioral health care in Maryland. The final Consultant Report provided an assessment of the strengths and weaknesses of Maryland's behavioral health care system as well as outlined two financing and integration models for the State: a protected carve-in and a risk-based carve-out (see pages 26-27 of the Consultant Report, included as Appendix I). In addition, the Department intends to develop a proposal to consolidate the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) to create a single Behavioral Health Administration covering both mental health and substance abuse.

Despite the strong work that had been done for the integration of behavioral health care to date, the Department was not yet prepared to choose an integration model. Instead, 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. This group was comprised of representatives from the Department of Health and Mental Hygiene, the Office of Health Care Financing, the Office of Behavioral Health and Disabilities, the Mental Hygiene Administration, and the Alcohol and Drug Abuse Administration (see Appendix II for complete Steering Committee membership).

Between March and September 2012, large public stakeholder meetings were held to inform the selection of a financing model. Three documents were developed by the Steering Committee, circulated for comment, and finalized as the first charge of this stakeholder process. These documents were used to guide the rest of the process. The first of these documents described three proposed finance and integration models to be considered for adoption by the State (two of which were outlined in the Consultant Report, one of which was added by the Steering Committee). The second document presented eleven criteria to be used 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. The third document outlined the charge of four workgroups to meet in addition to the large public stakeholder meetings, to focus on specific issues related to the selection of a financing model. These three documents are available as Appendices II-IV, respectively.

Written comments were accepted throughout the process and verbal comments were accepted at every workgroup and large public stakeholder meeting. Overall, *xxx* public comments were submitted during this process. Issues and discussions that arose in each workgroup were used to inform the large public stakeholder meetings, and final reports were written from each workgroup to inform the Steering Committee's final decision regarding model selection. These workgroup reports are available as Appendices V-VIII.

This report and the final recommendation are the culmination of all of the work that has occurred for behavioral health integration 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.

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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.

[Discussion of pros and cons]

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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.

[Discussion of pros and cons]

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Model 3: Risk-Based Population Carve-Out (New)

As in Model 1, all Medicaid-financed behavioral health benefits and general medical benefits would be delivered under a comprehensive risk-based arrangement. In this model, however, Medicaid would competitively select one or more specialty health plan(s) 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 SPMI. 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.

[Discussion of pros and cons]

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Recommendation

In consideration with the arguments presented for each model, the Steering Committee hereby recommends Model x. [explanation]

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Next Steps

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[i] 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).