

Stakeholder Comments: Behavioral Health Integration ASO RFP

1. Clinical Integration

Coordination of Care (ASO/MCO; REM case management; dual-eligibles and Medicare providers)

- 1) Primary care and MCOs should have ongoing coordination and consultation with behavioral health and oral health. Every child must have a PCP and oral health care provider.
- 2) With CSAs, identify, track, and collaborate on youth with high inpatient and ED utilization rates. Establish crisis response protocol to facilitate and track timely linkage of youth to available community crisis services to reduce emergency department utilization.
- 3) Maintenance of an identified and dedicated team of child- and adolescent-trained clinicians and professionals at all levels of the ASO to focus on child welfare, juvenile justice, 1915(i), Health Home, and RTC populations within the ASO and ensure ongoing availability of behavioral health consultation to child welfare, education/special education, and juvenile justice and to support shared responsibility between the ASO and the MCO for coordinating health care services for these populations.
- 4) Need for specialty delivery system for children, adolescents and youth with serious behavioral health disorders and their families. Children with serious behavioral health disorders have many more needs for coordination with social services, the courts and education (Missouri's SAMHSA HRSA January Webinar).
- 5) Ensure that consumers are connected to a PCP as a means of improving outcomes in PMHS. Health Homes won't help those without PRP and MT service.
- 6) The State of Michigan has developed a "care bridge" program that is designed to support coordination of behavioral health and somatic services. It was created in response to their problems with a carve-out system.
 - a) Note: The 8 elements of the program are included in original comment.
 1. Adapt a person centered approach in which the needs of the individual drives the care.
 2. The ASO provides or contracts with trained and qualified care coordinators. Coordinators working with individuals with substance use disorders (SUD) should have training and professional qualifications in the SUD field.
 3. Care coordinators should be regionalized so they are familiar of local services but there should be open access to services throughout the state
 4. Focus should be on care coordination across all settings, SUD, mental health and somatic
 5. Assures fidelity to integrated person-centered planning across all care and support team members
 6. Establishes role of lead coordinator responsible for assessment, care management and monitoring, and communication
 7. Supported by web-based technology that maintains centralized integrated care and supports record
 8. Accessible by person and his/her team members
- 7) The contact with the ASO and MCOs must spell out the coordinating mechanism. Any statute and regulations governing the MCOs should be amended to require coordination on both sides. Recommend investment in person centered Health Care Homes.
- 8) Having a case manager for patients with mental health and substance use disorders in both the MCO system and the ASO system could result in varying treatment approaches between the two case

management systems. The model must assure that there are not conflicting or varying treatment plans within case management.

- 9) DHMH should require that there is case manager to ensure that dual eligible receive appropriate services.
- 10) Establish at the beginning policies that support, if not incentivize, the development of complexity capable services, within somatic and behavioral health care. Many counties in MD already have these capabilities. Grants and policies could support them and encourage others to join this effort and increase capacity.
- 11) Please distinguish between coordination of coverage and coordination of care in its RFP. RFP should request information about how the ASO's payment system will be modified based on the rules and how the ASO's staff will be trained on the rules.
- 12) ASO and MCOs should establish a mechanism by which both patients and providers can easily get coverage information.
- 13) Coordination of care should be primarily handled at the provider level.
- 14) The ASO should have the capacity to help enrollees without a primary care/behavioral/specialty health provider to identify and initiate a clinical relationship with such a provider.
- 15) The ASO should have a defined program to identify REM-eligible individuals early and work vigorously with them to move to REM.
- 16) Create a system in which one of the behavioral health providers is given the responsibility to be the "coordinating provider" and supported by additional reimbursement.

Services Carved-in and Carved-out

- 1) Need to identify all services covered.
- 2) Services not performed in a normal PCP visit should be considered carved-out specialty services as in the somatic medical model, at least on the MHA side. Over-referral should be encouraged to allow the specialty system to determine whether more specialized services are necessary.
- 3) We support integrated delivery of mental health and substance abuse treatment but please consider ways to provide funds for training, monitoring, and provider incentives.
- 4) Although there is a recognized need to streamline the funding mechanisms, there is also an appreciation for the ability to tailor services to the needs of local communities. For grant funded services, funding mechanisms should be consolidated in a way that provides support to local priorities and needs.
- 5) There should be parity in payment regardless of whether the service is provided by somatic, substance abuse or mental health providers. Additionally, reimbursement for treatment of health behaviors such as smoking, obesity, poor adherence must be provided in an equitable way as with other mental health and substance abuse conditions.
- 6) The system should ensure that patients can have access to embedded mental health and substance abuse services in a primary care setting by whoever is needed. Patients with medical conditions being treated in a mental health or substance abuse setting must be able to receive comprehensive care for their medical conditions; medical clinics must be able to operate in mental health and substance abuse settings.

- 7) Would like to see Acupuncture as part of a comprehensive care option. The State should ensure that after-hours access to crisis services – both telephonic and facility-based - is appropriate.
- 8) Medication Assisted Treatment must be recognized as highly effective treatment for persons with opiate addictions. The ASO should fully and adequately cover medication as well as other necessary therapy to ensure full recovery for these individuals.
- 9) Residential care must continue to be offered at current levels, as an important component of the system.
- 10) The State must expand its commitment to adolescent substance abuse programs.
- 11) Tele-psychiatry programs, and other similar technology-based services, must be reimbursed in a manner consistent with traditional counseling approaches.
- 12) Treatment providers should be given substantial input into the rates established for services; and rates for all levels of care must enable providers to adequately cover the costs of providing each level of care.

Continuity of Care/Churn (moving between exchange, private plans, Medicaid, and non-insured)

- 1) Mobile crisis response, emergency department diversion and crisis stabilization should be provided to all residents of Maryland, regardless of their insurance-type. Mobile crisis and stabilization services can be included in the ASO's rate or incorporated into the State Plan. As appropriate, the ASO can bill the private insurance companies for services. For non-insured families, the ASO could utilize a sliding scale fee for any services provided more than 2 weeks past the initial crisis (per event).
- 2) Consumers should have up to 60 days from the date of notification that they are no longer Medicaid-eligible to receive services from Medicaid while transitioning to exchange or elsewhere.
- 3) RTCs should be allowed to provide services for youth in their care 90 days prior to transition home and for additional 90 days after youth returns to the community.
- 4) Data sharing, communication, and linkage requirements among Local Behavioral Health Authorities, ASO and MCOs will enable LBHAs to manage continuity of care and appropriate level of service in two areas: monitoring of frequent users of high-cost services (Medicaid and non-Medicaid), and those moving in and out of plans (churn.)
- 5) Concerned about network adequacy in the commercial market. DHMH as well as the Exchange will need to closely monitor carriers' networks of behavioral health providers and the impact on continuity of care.
- 6) ASO should honor treatment authorizations of relinquishing carrier for at least the required 90 days.
 - There must be clear continuity of care provisions for all Medicaid and non-Medicaid services consistent with the continuity of care provisions passed into law for non-carved out services.
 - The State must take all actions required to solve administrative, contractual or legal barriers to ensure full continuity of care. Actions may include, modifying contracts, proposing legislation, amending the State Medicaid plan or applying for waivers.

Communication requirements (expectations for ASO, MCOs, PCPs, and/or BH providers)

- 1) Requirement of 48-hour response for behavioral health screening for children entering child welfare (should also be required for physical health screens for mainstream MCOs); inclusion of the Maryland COMAR regulations governing screening and assessments for children entering child welfare placement into contracts for the ASO and MCO.
- 2) There must be incentives for MCOs to cover and encourage the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in emergency rooms and primary care settings. There should be incentives for MCOs to cover these services and coordinate with the ASO.
- 3) Requirement for a designated liaison with the adult side of the ASO for youth (16-24) who are transitioning into the adult system.
- 4) Require the ASO to consult with community providers, ideally prior to any "go-live" date, on service authorization and other protocols that have been working well and vs. those needing improvement.
- 5) Processes are put into place for regular and responsive collaboration with public behavioral health stakeholders, including community service providers, that ensures ongoing mechanisms to debug and troubleshoot program, policy and technical issues.
- 6) Confidentiality issues
 - a) The legality of sharing information between mental health and somatic providers was resolved at the initiation of the HealthChoice program. There is no legal barrier to sharing of information for the coordination of mental health and somatic care for Medical Assistance recipients.
- 7) Service providers are not always clear when their services are truly Medicaid services and when they use a look-a-like number (i.e., respite providers). Providers should be given information on the services that they provide and where they exist within the State Plan, statute, and regulations.
- 8) The ASO should have expertise in the use of the Child and Adolescent Needs and Strengths (CANS) tool to ensure strong communication with child welfare, juvenile justice, and other agencies and providers.
- 9) American Society of Addiction Medicine (ASAM) placement criteria should be used by the ASO to authorize services for each level of care and providers should have a significant voice in length of stay decisions. ASAM criteria, as required by Maryland law, must be followed and the clinical judgment of the treating behavioral health professional must be utilized in determining the necessary level of care for each individual served;
- 10) Before an MCO or ASO denies a Medicaid service on this ground, they should be required to communicate with each other. In every such case, the MCO or ASO was simply "passing the buck," and the other entity denied responsibility for coverage.
- 11) ASO and MCOs should establish a mechanism by which both patients and providers can easily get coverage information. ASO should be able to communicate with clinical and administrative staff about clinical issues.
- 12) Communication between the two entities - and the PCPs and behavioral health providers – is very important so that regardless of where a person enters the system, they can have access to the full range of somatic and behavioral health services.
- 13) Substance Use Disorder and other co-occurring disorder treatment coverage should assure that:

- i. Timely and appropriate access to care is available;
- ii. The quantity, location, and specialty distribution of health care providers is adequate; and
- iii. Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured

14) The State and the Medicaid managed ASO and MCOs should allow reimbursement of counseling, coordination, and consultation procedure codes to enable the appropriate array of professionals including primary care physicians to provide primary substance abuse treatment services in collaboration with Substance Use Disorder professionals.

15) The State and the Medicaid managed ASO should allow reimbursement for individual and group counseling, risk factor reduction interventions and family counseling for children and adolescents who are at-risk of Substance Use Disorder.

Non-Medicaid Services

1) How will the ASO manage non-Medicaid services such as the housing portion of Residential Rehabilitation Program services and service access to and payment for non-Medicaid-eligible individuals?

2) The MCO should be expected to partner with the ASO and with local health departments, CSAs, and providers to pay for evidence-based or promising practices, even if they are not contained in the State Plan. For example, MCOs should partner with and provide ongoing funding for B'More for Healthy Babies and Baltimore City Health Dept. to improve birth outcomes.

The inclusion of non-MA services and services for non-MA eligible individuals under the current mental health ASO has been strength of the system. Must define individual peer support services.

3) RFP should be written to allow for the flexibility to add and ability to serve all Medicaid-eligible and enrolled children (including SSI, TANF, foster care, and youth in the 1915(i) as well as additional populations as contracted by the State, and could potentially include funds from the Substance Abuse and Mental Health Block Grants, State General Funds, and other prevention and early intervention funds.

4) The state must work closely with both addiction treatment and mental health service providers to ensure there are adequate funds for the non-Medicaid services. We strongly advocate for retention of state-only dollars for these services as there will also be transition issues that may require financial assistance.

5) Early intervention services for very young children already experiencing social/emotional problems and family interaction problems should be covered by Medicaid's Public Mental Health System. Under the federal Medicaid statute's EPSDT mandate, states must provide preventive services for children under 21. DHMH regulations already recognize that the Medical Assistance Program covers preventive or early intervention services.

a) <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>.

b) COMAR 10.09.23, 10.09.40, and 10.09.50

c) Maryland's definition of what services are medically necessary

6) We want to also recommend that MCOs should cover home visiting programs such as the Nurse Family Partnership.

a) However, these services may be covered by Medicaid as a recent report from the Pew Charitable explains:

http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Home_Visiting/PCS_NASHP_HV_Medicaid.PDF

2. Data

Data Capabilities

- 1) MIS Interoperability
 - a) MIS should fully interface with other systems, i.e. pharmacy utilization, DHR's CHESSIE data system and DJS's ASSIST data system.
 - b) MIS should be web-based.
 - c) Should support connectivity with Wrap TMS, a web-based behavioral and integrated health record software product that is being customized for use in Maryland by Care Management Entities.
 - d) Care coordinators and case managers can view all authorizations for enrolled children and youth.
 - e) Interoperability should be achieved within 6 months of contract effective date.
 - f) Clarify in RFP if you have minimum requirement for extent to which state staff will have access to contractor's data system.
 - g) Office of Inspector General should have direct access to ASO's data (that is non-Medicaid services, or who the "pay to" was).
 - h) We must reduce burden of information reporting at provider level. Meaningful data should replace quantity of data.
 - i) ASO and MCOs will need to incorporate into their IT systems the rules on which services are reimbursed by ASO or MCO.
- 2) Data Collection
 - a) System should include data on the number of children in the PMHS and in RTCs, including information on past utilization.
 - b) Data collection efforts will likely be necessary at consumer registration for services, authorization for services and from claims. ASO should have mechanism to link client data across all services, points in time and across providers.
 - c) The Outcomes Measurement System data elements should be expanded to collect appropriate substance abuse items.
 - d) ASO should be required to track encounter and claims data for youth for behavioral health (mental health and substance use) services to support the development of the capitated rates.
 - e) Should be required to evaluate the sufficiency of the provider network on an ongoing basis and fill the gaps as appropriate – both geographic and types of services.
 - f) An up-to-date, online, searchable provider directory should be maintained to include provider expertise and identification of evidence based programs.
 - g) Meaningful data: criminal justice status including number of arrests, length of time of substance abuse use before treatment episode, number of previous treatment attempts, poverty , educational status, trauma history, co-occurring medical/ mental health/substance abuse, access to public transportation, employment status, learning disability, etc.
 - h) The State should measure access, quality, patient satisfaction, and costs associated with substance use disorder. The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service which can be used to measure the performance of substance use disorder services. The Agency for Health Research and Quality or AHRQ has developed the Experience of Care and Health Outcomes or ECHO Survey for managed behavioral healthcare.
- 3) Other
 - a) The software and systems developed and used by the ASO for this contract will remain in Maryland if and when the contract ends.
 - b) We recommend a workgroup be established to identify tools and protocols.

Data Sharing

- 1) MOUs and data sharing agreements should be executed within 6 months of contract effective date.

- 2) Requirements that will continue provision of these eligibility, provider, authorization, claims, pharmacy, and Outcomes Measurement System (OMS) data sets to the Behavioral Health Administration and maintained in a manner that easily relates them to historical data sets from PMHS.
- 3) The current plan reports substance abuse information through the TEDS system and mental health data through the Client Level Data project. Data elements for both of these systems should be included in reporting/recording requirements.
- 4) MIS should produce dashboard reports on service utilization, authorizations, diagnoses, and other child-specific features at the state and jurisdictional levels.
- 5) Should provide all needed data for federal and state reporting requirements, including but not limited to mental health block grant reporting, National Outcomes Measures, Uniform Reporting System (URS), Client Level Reporting and Consumer Survey requirements.
- 6) ASO should facilitate rapid and uncomplicated access to data by providers such as the medication data currently available, in a cumbersome way, via the Maryland Consumer Pharmaceutical Utilization Report.
- 7) There should be strong requirements regarding data sharing and communication between and among Local Behavioral Health Authorities, the ASO, and MCOs to ensure that the locals have access to timely information that allows them to do their jobs effectively.
- 8) There must be the capacity for data from each MCO and the ASO to be shared with releases provided by the patient. There must be the capacity to share non-identifying data from MCOs and the ASO to improve overall service delivery.
- 9) The MCOs should be required to collect and report data not just on all well child visits, but on the mental health screening being completed and the outcome.
- 10) The State should utilize opportunities available in federal initiatives related to data sharing.
<http://www.samhsa.gov/co-occurring/topics/data/data-sharing.aspx>
- 11) Invest in purchasing electronic record and billing systems that meet meaningful use requirements that allow access to federal incentive funds.
- 12) Make sure data sharing systems are compatible with HIE information
- 13) Are we attempting to use CRISP for transferring information?

3. Incentives

Measures to define for ASO and MCO (medical-, consumer-, operational-, and social-based outcomes)

- 1) Population served (with additional attention to race/ethnicity, gender, locality, and involvement in public child-serving systems—child welfare, juvenile justice, etc).
- 2) Service utilization (patterns and cost, attention to outliers, use of home and community versus restrictive services, patterns by child-serving system and locality).
- 3) Service quality (use of evidence-based practices, adherence to a family-centered and systems of care approach, inclusion of natural supports in service plans).
- 4) Cost (total, per child served, and for each of the child-serving systems).
- 5) Outcomes at the child, program, and system level, to be determined in conjunction with MHA and ADAA, to be reported by the third year of the contract.
- 6) Family, youth and agency experience of the system through consumer satisfaction surveys.
- 7) Expand the Outcome Measurement System (OMS) to include mental health and substance use measures. Get consumer and provider input into tool development.
- 8) Experience, including winning CMS support.
- 9) ASO contract should also focus on parity and helping DHMH identify instances where private insurance isn't covering benefits that they should. As an example, Crisis Response and Stabilization.

Methodology for financial incentive (shared savings, sanctions, bonuses, withholds)

- 1) Creative pay-for-performance strategies within an ASO structure that could include a shared savings model for high performing behavioral health providers; however, some savings should be re-invested in the system from which the savings were generated.
- 2) DHMH and the ASO could enter into pilot programs with specific types of behavioral health providers to include performance-based payments that incentivize improved quality and effectiveness of care. This could inform the rate-setting process for capitation under a risk-based model.
- 3) The current public mental health system reimbursement and grant system for non-Medicaid services, and the integration of these services with Medicaid services, is working well. Therefore, we urge the Department to retain all of that as is, and add non-financial incentives such as relaxation of administrative requirements based on shared Medicaid savings and performance indicators.
- 4) Any shared savings methodology should encourage the integration of primary and behavioral health care at the provider level.

Financial incentives for providers (similar to Patient-Centered Medical Home pilot)

- 1) Should not negatively influence consumer access to services or provider/consumer reporting of data/outcomes.
- 2) Provide positive incentives such as bonuses as opposed to withholds and relaxed utilization review and other administrative shortcuts for behavioral health providers.

- 3) MCOs and primary care practitioners are rewarded for a) collaborating with behavioral health providers in care integration arrangements and b) ensuring fair and reasonable sharing of allowable savings generated by effective behavioral health services.
- 4) BH Providers who are providing integrated service including co-locating services, providing on site primary care practitioners and utilizing a multidisciplinary team approach and collecting and sharing outcome data should receive enhanced payment for services.
- 5) Small specialty providers should have access to incentive programs for integrating care by partnering and coordinating with primary care providers.
- 6) Risk-based case rates for specialty services or populations could be established to move toward better efficiencies of service, quality and cost. This could include the use of particular evidence-based practices and emerging best practices, as well as Care Management Entities (CMEs) for particular populations of youth with serious emotional disorders.
- 7) Help providers meet “meaningful use” standards for electronic health records (EHRs), which will help providers tracking of established core outcomes.
- 8) Give financial incentives to providers for adapting new technology, electronic records and information sharing with other health providers.
- 9) Financial incentives must also include consumer satisfaction/perception
- 10) Provider level incentives should be community integrated; improve Big 4 factors BP, A1C, CHOL, and Weight.

4. Organizational & Administrative Requirements

Staffing & Credentialing

- 1) *Accreditation:*
 - a) ASO maintains appropriate accreditation;
 - b) ASO should be expected to serve as credentialing body to enroll providers.

Specify provider network accreditation/credentialing requirements
- 2) All employees involved in approval of behavioral health services must receive special training focused on behavioral health services;
- 3) ASO staff, involved in the management of Substance Use Disorders, should have sufficient training and experience including at least one of the following certifications or licensures as behavioralists:
 - 1) state certification or state licensure in the Substance Use Disorder profession;
 - 2) national certification as addiction counselors;
 - 3) certification as addictions registered nurses ;
 - 4) certified by ASAM in Addiction Medicine;
 - 5) certified by the American Board of Psychiatry and Neurology, ABPN, in addiction psychiatry;
 - 6) certified by the American Society of Addiction Medicine.
- 4) The Medicaid managed ASO should allow for an appropriate range of licensed and certified professionals and safety net providers trained or experienced in substance use disorder prevention, assessment, evaluation, and treatment services.

- 5) *Child & Adolescent Staffing:*
 - a) Required hiring of child- and adolescent-trained clinicians.
 - b) Required lead child and adolescent services coordinator.
 - c) Required staff member trained in youth of transition age (12-24).
- 6) Required family member liaison as part of customer service.
- 7) ASO should have a Consumer Advisory Board and Consumer Affairs department with an ombudsman/ consumer advisor. Or the ASO should have an office consumer affairs or recovery department. It would make any potential consumer advisory board or focus groups unnecessary.
- 8) You should clarify any requirements of ASO's governance structure/composition in the RFP.
- 9) To ensure an understanding (removing stigma) about the role of medication in addiction treatment, administrative staff involved with behavioral health at DHMH should be trained.
- 10) *Credentialing:*
 - a) We urge the Department to work with MCOs to develop a streamlined credentialing for Chronic Health Home providers.
 - b) We urge Medicaid to credential treatment programs, allowing appropriately licensed professionals and certified professionals under appropriate supervision within a certified or accredited program to be reimbursed for services.
 - c) We should create a workgroup of consumers and providers to tackle credentialing process, which is currently seriously flawed.
- 11) Current Medicaid regulations allow a licensed health occupations professional to review the work of a certified addictions counselor (i.e. tx plan being submitted for authorization) - need to preserve the credentialing requirement as it exists so as not to create workforce shortages.
- 12) Include individually licensed practitioners as eligible providers who can be reimbursed by Medicaid.
- 13) MCO PCPs are trained to do appropriate mental health screenings at all well child visits as required under EPSDT. Training and ongoing oversight such as through B-HIPP is needed.

How will the unique nature of HSCRC regulated practice settings be addressed in the RFP to ensure that these Hospital based practitioners of both inpatient and outpatient services can fully function and be compensated within the revised structure?

Other

- 1) Certificate of need
 - a) ASO should coordinate with local BH authority in completion of certificate and ruling out alternative placement.
 - b) ENSURE THAT THE RFP CONTAINS LANGUAGE ABOUT THE CERTIFICATE OF NEED PROCESS for both RTCs and 1915(i) eligibility which includes the shared responsibility and partnership in decision making between the ASO and the CSA's.
- 2) There should be an appeal, grievance and dispute resolution process developed to quickly resolve disputes between providers and the ASO. This function should be delegated to an objective third party and the protocols should provide for quick, lawful and appropriate resolution.
- 3) Appeals and grievances process should be easy to access for both beneficiaries and providers but should be "beneficiary-centered."

- 4) Rather than an advisory board, we should have DHMH conduct period focus groups of active users and non-users of ASO to get real-time feedback.
- 5) There should be a process developed to quickly resolve billing disputes between the MCO, ASO and providers. Again, this function should either be delegated to an objective third party and the
- 6) protocols should provide for quick, lawful and appropriate resolution. Complaint resolution process needs to be easy for consumers.

5. Pharmacy

- 1) ASO should be required to monitor use of psychotropic medications using the State's guidelines. For example, the ASO could partner with the current anti-psychotic Peer Review Project for children and adolescents.
- 2) Upon request, the ASO should provide behavioral health consultation (adult and child-specific) to the MCOs and primary care practitioners (Behavioral Health Integration in Pediatric Primary Care, B-HIPP and the Massachusetts Child Psychiatry Access Project model, particularly with regard to the prescribing of psychotropic medications.
- 3) ASO should continue to have access to information on psychotropic medications so they can effectively identify consumers and prescribers who may require additional support.
- 4) There is no reason that medications used in the treatment of mental health and substance abuse should be treated differently. It should not be difficult to add those medications into the process currently used in mental health treatment. It does not seem necessary to have an authorization process for medication in addition to any authorization for treatment.
- 5) A major difference in our two systems is the reimbursement of physician services within treatment programs in the administration of buprenorphine. It is currently reimbursable in a mental health program, but not in a substance abuse treatment program. These services should be reimbursed regardless of venue. This and other differences in our systems should be reconciled and implemented as soon as possible.

6. Authorization & Utilization Rule Development

- 1) Primary care providers should retain the ability to provide appropriate behavioral health services to ensure to: 1) enhance the integration of behavioral health and somatic services; 2) protect access to services, including but not limited to, the provision of buprenorphine and the treatment of depression in older adults.
- 2) State funded mental health services should continue to be authorized and reimbursed through the ASO on a fee-for-service basis to allow for continued integration of Medicaid and state funded services.
- 3) Include " Pay for Performance" measures.

- 4) Consideration should be given to utilizing the ASO structure for consumer registration and data collection for client services (not population-based services-e.g. prevention) currently funded through contracts, as appropriate, in order to most effectively utilize the range of services in the public behavioral health system and to obtain information/data on service utilization.
- 5) Individuals seeking addiction treatment services should have no barriers to accessing care, especially through any lengthy or complicated pre-authorization process.

7. Other

- 1) Use of the Early Childhood Service Intensity Instrument (ECSII) and the Child and Adolescent Service Intensity Instrument (CASII) to assist in decision-making.
- 2) The ASO should be required to fully support the guiding principles of Maryland's Systems of Care.
 - a) Note: sample language for Background Section provided in original comment submission
- 3) ASO should partner with the State to achieve 3 systemic goals.
 - a) Reduce out-of-home placements and lengths of stay.
 - b) Ensure better access to care for children and youth in all child-serving systems, particularly in the Department of Human Resources and Department of Juvenile Services.
 - c) Reduce disproportionality and disparity in access to and receipt of services and supports by race, ethnicity, and geography.
- 4) The experience of the MHA in the 1997 PMHS fee-for-service implementation provided several valuable lessons (listed below). They may suggest a need to require the ASO to provide technical assistance to provider community in early phase of implementation.
 - a) LHDs have 20% disadvantage in their basic cost structure with fee-for-service system when compared to private non-profit or for-profit entity. The number of LHDs providing PMHS services reduced significantly after 1997.
 - b) Many agencies weren't prepared, particularly in terms of their billing capabilities, for a managed care system that required authorization.
- 5) Building in safety net for uninsured clients is essential or they will be turned away from care.
- 6) Unrelated to RFP: Maryland Medical Assistance Program should continue working with the Exchange on evaluating its network adequacy requirements. We're concerned that the QHPs will have inadequate networks, especially in behavioral health. We should find a way to ensure that QHPs have Medicaid/safety net providers.
- 7) How will you address and make room for uncertainties and other things we aren't aware of now but might come up down the road? We don't want to kick ourselves later if we forget to include something but it's too late. Will you somehow leave room for flexibility in the RFP?
- 8) What factors should be assessed and what methodologies should be used for risk assessment? How do we take into account differences in the consumers being served?