Maryland Behavioral Health Coalition

1301 York Road ♦ Suite 505 ♦ Lutherville, Maryland 21093 ♦ (443) 901-1550 ♦ FAX (443) 901-0038 ♦ info@mhamd.org

October 2, 2017

Dennis R. Schrader
Office of the Secretary
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201-2399

RE: Strategy to Improve Behavioral and Somatic Health Integration in the Maryland Medicaid Program

Dear Secretary Schrader:

The 100+ undersigned organizations of the Maryland Behavioral Health Coalition present for your consideration the following strategy to improve integration of behavioral and somatic health services in the Maryland Medicaid Program. We offer these recommendations to assist the Maryland Department of Health (MDH) in its preparation of reports on integration required by the Centers for Medicare and Medicaid Services (CMS) and the Maryland General Assembly.

Last November, the Coalition issued a policy paper highlighting strengths of Maryland's current public behavioral health system in the areas of access to care, quality of services and cost effectiveness – and recommending a series of enhancements to improve outcomes and efficiency. We believe that a major change in the structure and financing model would increase administrative spending, consume limited resources, cause unintended consequences, disrupt an already fragile provider network and divert attention from ongoing initiatives to improve clinical integration and reduce costs. However, we recognize that the current system, like all systems, can benefit from improvement in several areas.

We believe that the following transformational strategy will improve the integration of behavioral and somatic health services in Maryland.

A. Program Enhancements

***1. Enhance the Medicaid Chronic Health Home Program*.** As noted in MDH's response to the 2016 Joint Chairmen's Report, the Medicaid Chronic Health Home Program is a relatively new, promising integration initiative which has dramatically increased the integration of behavioral health and somatic care for eligible Medicaid beneficiaries. The Chronic Health Home Program has enabled behavioral health providers to embed primary care nurses into behavioral health teams as care managers, more effectively address somatic care issues and coordinate care with somatic providers, access both behavioral health and somatic care data, implement population health management and utilize data analytic tools to develop data-driven care. We believe the Department's evaluation data will demonstrate that the program's implementation has had significant clinical integration benefits and a decrease in total behavioral and somatic health costs. We encourage the Department to maximize this new program by giving it more time for implementation, technical assistance and design fine-tuning. Furthermore, if, as we predict, program evaluation data demonstrates a net cost savings, then we also recommend that MDH explore expanding the program to include other individuals with behavioral and somatic health conditions who are not currently eligible. Current provider participation is limited to Psychiatric Rehabilitation Programs, Assertive Community Treatment Teams and Opioid Treatment Programs (OTP). Expansion to

include Outpatient Mental Health Centers (OMHC) and other Substance Use Disorder (SUD) programs would reach the majority of individuals served in the Public Behavioral Health System.

2. Implement Comprehensive Primary Care Model for People Dually Eligible for Medicare/Medicaid. With assistance from CMS, MDH and stakeholders have spent the past two years designing a system that will better manage the care and costs of people who receive both Medicare and Medicaid, a population that is not included in the HealthChoice Program. The model involves assigning beneficiaries to primary care practices that will serve as Person-Centered Health Homes (PCHH). Special attention in the design was given to Medicare/Medicaid beneficiaries with behavioral health conditions because MDH data revealed that Psychosis is one of the diagnoses associated with the highest overall medical costs in the population. For those beneficiaries who are served by Medicaid Chronic Health Homes, the model allows the individuals to select those Medicaid Health Home providers to also be their Medicare PCHHs. Therefore, the design permits the use of Medicare funds to enhance the Medicaid Chronic Health Homes for those dually-eligible beneficiaries. We specifically recommend that those Medicare funds be used to increase the ratio of primary care nurses embedded in Chronic Health Homes. This enhancement will significantly enhance the integration of behavioral and somatic health services for thousands of Medicaid beneficiaries living with the most serious behavioral health conditions. In addition, if evaluation data indicates success of this enhancement for Medicare/Medicaid beneficiaries, we recommend a replication of the enhancement for Medicaid-only Chronic Health Home patients. Furthermore, we recommend that the Department permit OMHCs and non-OTP SUD programs to be Medicare PCHHs if those programs become Medicaid Chronic Health Homes pursuant to the expansion proposed in Recommendation A1 above. Finally, we recommend that MDH explore piloting a Duals Accountable Care Organization (ACO) model in a select region.

3. Require Primary Care Providers and Managed Care Organizations (MCO) to Implement Collaborative Care Practice Protocols for Individuals with Mild to Moderate Behavioral Health Conditions. For nearly 20 years, Maryland's Medicaid waiver has required the delivery of primary mental health care (i.e. treatment for common depression and anxiety disorders) within the MCOs, and reimbursement for these services is included in MCO capitation rates. Unfortunately, while a majority of individuals receive their mental health care from their primary care provider, national data indicates that mental health treatment in these settings is often sub-optimal, with individuals poorly diagnosed and treated or not identified at all. Collaborative Care is an integrated care approach for treating common mental health conditions through team-based care management, tele-psychiatric consultation and routine monitoring of outcomes using evidence-based tools, for which CMS implemented reimbursement codes in the Medicare program effective January 2017. Validated in more than 80 randomized controlled studies, the model improves clinical outcomes and saves up to $6 for every $1 invested. Although MDH recently identified Collaborative Care as the evidence-based practice with the strongest demonstrated results for integrating mental health treatment with primary care, and recommended the development of a limited pilot program, no funding was included in the fiscal 2018 budget. Rapid implementation of this model within the MCOs will result in improved behavioral health outcomes and decreased overall health care costs.

B. Strategies to Improve the Sharing of Health Information

1. Implement Strategy for Using Health Information Exchange (HIE) to Share Both Behavioral and Somatic Health Data. Maryland is fortunate to have the Chesapeake Regional Information System for our Patients (CRISP), which is one of the most innovative and effective HIEs in the country. CRISP is planning to implement an innovative, open source software application called 'Consent2Share,' which will allow providers to access behavioral health data through the CRISP interface if those providers are specified in

stored patient consents that comply with the federal 42 CFR Part 2. Integration would be substantially enhanced with this progressive HIE that can provide both behavioral and somatic health data to both behavioral and somatic health providers. We urge the Department to continue supporting the implementation of this new initiative.

2. Require MCOs to Provide Relevant Somatic Health Data to the Administrative Services Organization (ASO) and Implement Performance-based Standards for MCOs to Share this Clinical Data. Currently, the ASO, Beacon Health Options, shares the vast majority of its clinical mental health and substance use data with the MCOs to support coordination of care. In contrast, the MCOs do not currently share any clinical data with Beacon. It is our understanding that the current contract with Beacon Health Options was designed with expectations that it would regularly receive somatic health data so that (1) the ASO could provide yet another avenue for integrating behavioral and somatic health care, and (2) to meet certain related contract expectations. However, it does not appear that somatic health data is being shared, and, as a result, the metrics built into the ASO contract have not been enforced. We recommend that relevant, agreed-upon somatic health data be shared, and that the MCOs and ASO meet regularly to discuss that data and collaborate, including efforts to ensure that the data is available at the provider level where it is the most needed to enhance integration. We also recommend that the ASO contract metrics be enforced and that any barriers to data sharing be resolved.

3. Address MCO Concerns about Behavioral Health Data. A small subset of MCOs continues to express concerns about the lack of access to behavioral health data collected by the ASO. These concerns can best be addressed through a publicly transparent process that brings together MDH, MCOs, Beacon, providers, legislators and other stakeholders to identify the specific issues of concern and to recommend actionable solutions to address valid concerns.

C. Additional Strategies to Improve Integration

1. Implement Shared-savings and/or Performance-Based Payments for Providers of Behavioral Health and Somatic Health Services that Further Incentivize Clinical Integration. Innovative payment methodologies based on savings of combined behavioral and somatic health services will be introduced and piloted in the system for Medicare/Medicaid beneficiaries with behavioral health conditions through the Comprehensive Primary Care initiative discussed in Recommendation A2 above. These payment methodologies will incentivize closer attention to both types of services and more intensive collaboration between both kinds of providers. This strategy could be replicated for providers serving Medicaid-only individuals. In addition, performance-based payments should be piloted and implemented in the current Medicaid system, using existing or readily available performance measurements such as the Outcome Measurement System (OMS), the DLA20 and Validated Patient Reported Symptom Rating Scales as they relate to the intersection between behavioral and somatic health**.**

2. Implement Incentives for Providers to Co-locate Primary Care Services in Behavioral Health Facilities. Some community behavioral health organizations currently have arrangements with federally-qualified health centers and other primary care practices to provide primary care services in behavioral health facilities. This practice enhances integration between behavioral and somatic health care by increasing access to both types of services and increasing collaboration between the professionals delivering those services. We recommend that the Department encourage more widespread implementation of this practice by offering providers non-financial assistance, such as (1) developing a learning community so that agencies that are currently offering this service can provide technical assistance to other

organizations, and (2) clarifying behavioral health billing regulations that could be misinterpreted to create disincentives to this practice.

Thank you for considering these recommendations. We are confident that this strategy would have a positive effect on the delivery of integrated care in the Maryland Medicaid Program. If you have any questions, please contact Dan Martin at (410) 978-8865 or via email at dmartin@mhamd.org.

We look forward to your response and would appreciate an opportunity to meet and discuss this information in greater detail.

Sincerely,

Baltimore City Substance Abuse Directorate
Baltimore Crisis Response, Inc. (BCRI)
Baltimore Jewish Council (BJC)
Center for Addiction Medicine (CAM)
Community Behavioral Health Association of Maryland (CBH), representing:
- Archway Station
- Arundel Lodge
- Aspire Wellness Center
- Board of Child Care
- Catholic Charities
- Carroll County Youth Services Bureau
- Center for Children
- Channel Marker
- Community Connections
- Community Residences
- Corsica River, Inc.
- Cornerstone Montgomery
- Crossroads Community
- Eastern Shore Psychological Services
- Family Service Foundation
- Family Services, Inc.
- Garrett County Lighthouse
- Goodwill Industries/STEP
- Harford-Belair Community Mental Health Center, Inc.
- Humanim
- Institute for Family-Centered Services
- Key Point Health Systems
- Leading by Example
- Life Renewal Services
- Lower Shore Clinic
- Mosaic Community Services
- Omni House Behavioral Health
- Pathways
- PDG Rehabilitation Services
- People Encouraging People
- Prologue

- Psychotherapeutic Treatment Services
- Reginald Lourie Center, Rehabilitation Systems, Inc.
- Southern Maryland Community Network
- The Children's Guild
- The Mental Health Center of Western Maryland
- Therapeutic Living for Families
- Upper Bay Counseling & Support Services
- Vesta
- Volunteers of America
- Way Station
- WIN Family Services

Health Care for the Homeless
Healthy Harford
Jewish Community Services
Licensed Clinical Professional Counselors of Maryland (LCPCM)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Association of Behavioral Health Authorities (MABHA), representing:

- Allegany County Behavioral Health Systems
- Anne Arundel County Mental Health Agency
- Anne Arundel County Local Addiction Authority
- Behavioral Health System Baltimore
- Baltimore County Local Behavioral Health Authority
- Calvert County Core Service Agency
- Calvert County Local Addiction Authority
- Mid-Shore Behavioral Health, Inc.
- Caroline County Local Addiction Authority
- Carroll County Local Behavioral Health Authority
- Cecil County Core Service Agency
- Cecil County Local Addiction Authority
- Charles County Local Behavioral Health Authority
- Dorchester County Local Addiction Authority
- Mental Health Management Agency of Frederick County
- Frederick County Local Addiction Authority
- Garrett County Behavioral Health Authority
- Office on Mental Health of Harford County
- Harford County Local Addiction Authority
- Howard County Mental Health Authority
- Howard County Local Addiction Authority
- Kent County Local Addiction Authority
- Montgomery County Department of Health and Human Services
- Prince George's County Core Service Agency
- Prince George's County Local Addiction Authority
- Queen Anne's County Local Addiction Authority
- Somerset County Core Service Agency
- Somerset County Local Addiction Authority
- St. Mary's County Local Behavioral Health Authority
- Talbot County Local Addiction Authority
- Washington County Mental Health Authority

Washington County Local Addiction Authority
Wicomico County Behavioral Health Authority
Worcester County Local Behavioral Health Authority
Maryland Behavioral Health Network (MBHN)
Maryland Clinical Social Work Coalition, sponsored by the Greater Washington Society for Clinical Social Work
Maryland Coalition of Families (MCF)
Maryland Coalition on Mental Health and Aging
Maryland-DC Society of Addiction Medicine (MDSAM)
Maryland Nurses Association (MNA)
Maryland Occupational Therapy Association (MOTA)
Maryland Psychiatric Society (MPS)
Maryland Psychological Association (MPA)
Mental Health Association of the Eastern Shore
Mental Health Association of Maryland (MHAMD)
National Alliance on Mental Illness, Maryland (NAMI Maryland)
National Association of Social Workers, Maryland (NASW Maryland)
National Council on Alcoholism and Drug Dependence, Maryland (NCADD Maryland)
On Our Own of Anne Arundel County
On Our Own of Maryland
On Our Own of St. Mary's, Inc.

cc: J. David Lashar, Chief of Staff
Webster Ye, Deputy Chief of Staff
Barbara J. Bazron, Ph.D, Deputy Secretary for Behavioral Health