Maryland Psychiatric Society Statement on Behavioral Health Integration

The MPS represents over 700 psychiatric physicians in the state of Maryland, and can speak for the 400 psychiatric physicians in the Southern Maryland Psychiatric Society as well as several hundred other unaffiliated psychiatrists. We have been very involved in the many discussions over the past months regarding the integration of mental health, addiction treatment, and somatic health care. We strongly believe that the best way to achieve the Department's goals of whole-person coordinated care, performance-based payments that focus on outcomes over volumes, integration of financial, care delivery, and data systems, and full data transparency for stakeholders that enable these goals, is to create a health care delivery model for Medicaid that unites somatic and behavioral health care in a manner that aligns the incentives of the payors, clinicians, patients, and the State.

The preponderance of the behavioral health stakeholders appears to be settling on a continuation of our current ASO model with some tweaking to provide performance-based risk and behavioral health homes. The MPS believes that the current model is significantly flawed, and do not support continuing down the same road solely because it is the road that we have come to know and trust. Maryland has a history of health care innovation, often leading the nation with unique and creative solutions to our health care challenges. We believe that, with whatever infrastructure model that is selected, a ***culture of integration*** must be developed.

While continuing our current ASO model may be the easier direction to move along, maintaining a carve-out approach, where one legal entity manages care above the neck and another one manages below the neck retains a separation that makes a culture of integration nearly impossible. When the entity that pays the bill for a service depends on which side of the neck, each will naturally want to point to the other side as responsible. This is the reason that the American Psychiatric Association has maintained a Position Statement against carve-outs for the past ten years. This way of "managing" care contributes to barriers to demonstrating compliance with the Mental Health Parity and Addictions Equity Act, because the two entities do not compare notes on how they manage care,

often leading to inequities in nonquantitative treatment limitations, such as more restrictive authorization procedures and more limited access to care via inadequate clinician networks. This separation also contributes to the foreshortened lifespans -- by as much as 25 years! -- of people with mental illness which is surely in part due to poor access to somatic care services.

The data provided by the Data Work Group clearly and profoundly demonstrate this disparity in chronic medical problems among the 200,000 or so HealthChoice enrollees. People identified as having a mental health illness are *medically* admitted 2- to 4-times more often for diabetes, heart failure, infections, epilepsy, and pulmonary disease than are people without any behavioral health condition. People identified as having a substance use disorder are *medically* admitted 4- to 7-times more often than people without any behavioral health condition. And, for people who have both mental health and substance use illness, these people are admitted *8- to 15-times more often* than those without. We have attached a graph of these astounding statistics to this letter. We estimated the cost for hospitalization for these conditions alone, and only for the 19-64 year old age group that we analyzed, to be about $86 million in excess costs over and above what would be expected for people without a behavioral health illness. A full analysis of this data would likely demonstrate over $150 million in excess costs, much of which is avoidable with improved outpatient care.

The MPS believes that a model that is most likely to adopt a culture of integration is also the one that will most likely reduce these avoidable costs and improve the health care of this population. It is clear that some of the proposed models are more or less likely to deliver a culture of integration and innovation. DHMH should ensure that the chosen model is hard-wired to contain the following features:

1. financial rewards and penalties for the payor(s) should be integrated in such a manner that they are incentivized to coordinate services and prevent negative outcomes regardless of who is paying the bill. If the ASO denies a service and this results in an $80,000 bill to the MCO for hospitalization after a suicide attempt, the ASO should be at risk for part of this bill. Similarly, if the MBHO provides case management services that results in improved diabetes care management that leads to reduced hospitalization costs for the MCO, the MBHO should share in those savings. There should be no opportunities for one payor to point to the other payor and say “not me.”

2. financial rewards and penalties for the clinicians should be integrated such that they are incentivized to pay attention to both somatic and behavioral health (BH) needs. This may include case management services that help behavioral health clinicians coordinate with somatic clinicians and services, as well as collaborative BH services that coordinate with PCPs.

3. minimize administrative overhead such that the maximum proportion of expenditures are spent on direct care and coordination of services.

4. the spirit and letter of the Mental Health Parity and Addictions Equity Act should be proactively maintained. The payor must “provide a detailed analysis demonstrating that their utilization management protocols do not have more restrictive nonquantitative treatment limitations compared to those used on the somatic side. The term “protocol” includes “…any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits.”

5. if the organization delegates any of its responsibilities to another contracted organization, it must “specify that the contractor shall comply with, and maintain parity between the MH/SUD benefits it administers and the organization's medical/surgical benefits pursuant to the applicable federal and/or state law or regulation and any binding regulatory or subregulatory guidance related thereto.”

6. descriptions of the processes that the organization uses to ensure compliance with regulatory health care parity requirements, including regulations pertaining to mental health and/or substance usage disorders (MHPAEA), including:
    a. periodic internal monitoring and auditing of compliance
    b. periodic review and analysis to determine if there are any changes in its benefits, policies and procedures, and utilization management protocols that impact compliance
    c. periodic communication to delegated contractors regarding changes impacting compliance, including parity of health care services such as mental health and/or substance use disorder parity (MHPAEA)

7. a comprehensive list of services and procedures that support integrated and comprehensive recovery models must be available to clinicians and consumers.

8. integration must include all levels and aspects of care – Emergency Departments, all Inpatient Hospital Care, Partial Hospitalization, Nursing Homes, Assisted Living Facilities, Group Homes, Residential Programs, Day Programs, Outpatient Care, Diversion Programs, Pharmacy including all medications, and all types of care including mental health, somatic and addiction care.

9. either require coordination of clinical information via the state-designated HIE or provision of a shared electronic health record service for all integrated care, with appropriate provisions to protect patient privacy.

10. financial, administrative, and clinical data collection systems must be integrated to permit analysis of expenditures associated with patient outcomes.

11. consumers should be allowed to receive services from any willing clinician.

12. the comprehensive list of services that patients may receive must be developed using a recovery-based model and covered under the integration of services.

13. data transparency for all stakeholders is critical for trust and success.

14. an oversight group of stakeholders will monthly review integrated data from all payor sources (MCO, ASO, MBHO, etc) and service utilization sources (ADT, Pharmacy, etc) for the purposes of ongoing review and ensuring coordination of care.

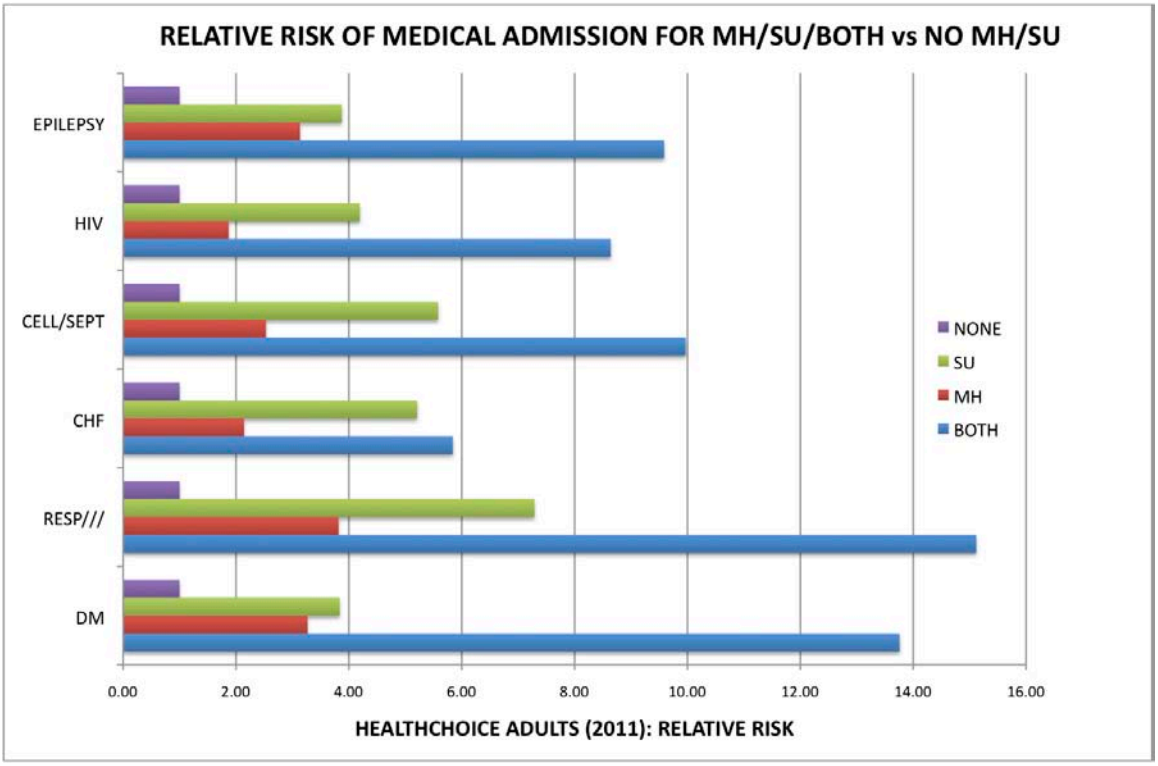
15. spreadsheets must be developed that permit ongoing ability for stakeholders to view levels of care being provided and denied, as well as their outcomes, for all patient subpopulations at a granular level.

16. standards should be developed for network provider directories that ensure accurate and up-to-date contact information as well as the ability to indicate if a provider is able to accept new outpatients in a timely manner.

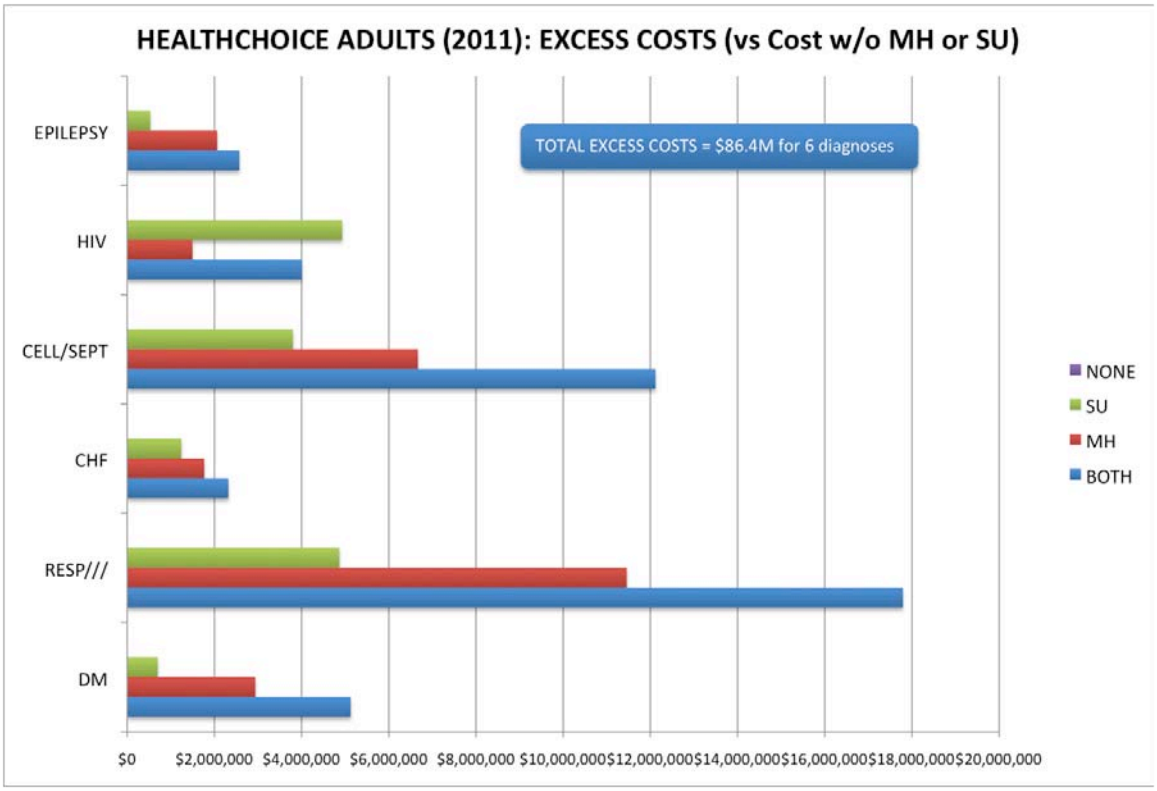
Thank you for considering our opinions and recommendations. We look forward to working closely with you as we enter Phase 3 of our discussion in making this house a home that is welcoming to all Medicaid consumers with any health problems, no matter what door they come in from.

Sincerely,

Scott Aaronson, MD, Vice-President
Steven R. Daviss, MD, APA Assembly Representative



* RESP///=Pneum NOS + COPD + Asthma + Bronchitis. CELL/SEPT=Cellulitis + Septicemia
* based on data from BH Integration Data Workgroup



These charts demonstrate the reason to include somatic costs in any model.

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