MARYLAND
Department of Health

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

February 26, 2018

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

**Re: 2017 Joint Chairmen's Report (p. 87) – Report on the Approach for the Integration of Behavioral and Somatic Services**

**2017 Joint Chairmen's Report (p. 89) – Report on Collaborative Care Revisited**

Dear Chair Kasemeyer and Chair McIntosh:

Pursuant to the requirements of the 2017 Joint Chairmen's Report (p. 87 and 89), please find enclosed an addendum report on the Department's approach for the integration of behavioral and somatic services and an update report on collaborative care which adds to the previously submitted 2017 Joint Chairmen's Report (p. 79) on January 8, 2018 (also attached). The report provides an update on the Department's plans for improving behavioral health integration and includes an update report on the collaborative care pilot project.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Deputy Chief of Staff at (410) 260-3190 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Enclosure

**Behavioral Health Integration Update**

**Collaborative Care Revisited**

Submitted by the Maryland Department of Health

2017 Joint Chairman's Report
Page 87 and Page 89

## I. Executive Summary

Effective January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a period of five years. As part of the waiver, the Department committed to developing a strategy to integrate physical and behavioral health care services in order to improve health outcomes for beneficiaries with substance use disorder (SUD) in the Maryland Medicaid Program. CMS requires the Department to produce a concept design for an integrated care model by July 1, 2018, with the goal of implementing physical and behavioral health integration by January 1, 2019.

Pursuant to the 2017 Joint Chairmen's Report (JCR) (p. 87), the Maryland Department of Health (the Department) submits this report as an addendum to the Behavioral Health Integration Report on Combining CSAs with LAAs in Various Jurisdictions Report submitted on January 8, 2018. A copy of the previous report is attached for your convenience.

In addition, this addendum report, pursuant to the 2017 JCR (p. 89), contains an update to page 78 of the 2016 JCR (the Department submitted a report regarding the opportunities to adopt a collaborative care model in the Medicaid Program).[1]

In addition to the recommendations identified in the earlier Behavioral Health Administration report, the Department will focus on revising performance-based outcome metrics for its ASO, further consideration of a Collaborative Care Pilot, and continue its work on provider integration on both the state and local level.

## II. Initiatives Underway to Support Behavioral Health Integration

Since implementing the SUD carve-out in 2014, the Department has engaged in a variety of initiatives designed to improve the integration of behavioral health services for Medicaid participants. These efforts include implementing individual release of information (ROI) forms from Medicaid participants accessing SUD services through the ASO to facilitate data sharing with the MCOs; introducing new guidance on the provision of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to encourage Medicaid providers to incorporate screening into their practices; and continuing support for and evaluation of the Health Homes established in October 2013 under Section 2703 of the ACA.

[1]2016 Joint Chairmen's Report on Collaborative Care Initiative, https://mmcp.health.maryland.gov/Documents/JCRs/2016/collaborativecareJCRfinal12-16.pdf.

**Implementation of ASO Performance Measures**

One overarching goal of the behavioral health integration effort was to implement performance-based standards for the ASO. The current contract with the ASO originally included outcome-based standards based on six HEDIS measures:

- Antidepressant Medication Management (AMM);
- Follow-up Care for Children Prescribed ADHD Medication (ADD);
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA);
- Mental Health Utilization (MPT);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET); and
- Plan All-Cause Readmissions (PCR).

The ASO was unable to meet the required HEDIS deliverables, as the ASO did not have access to the necessary somatic data. In addition to data sharing obstacles, the Department further identified that certain measures could not be assessed accurately. For example, the original performance metrics assumed a percent change for each month over a twelve month period. However, MMIS2 data are not considered complete until 12 months have passed for submission of fee-for-service (FFS) claims and six months for submission of managed care organization (MCO) encounters, which would create challenges assessing changes on a monthly basis.

The Department is in the process of reviewing five new performance metrics for the ASO to replace the 6 HEDIS measures originally included in the current contract.

The new proposed ASO performance measures are as follows:

1. Follow-up After Behavioral Health Hospitalization (Two appointments will be measured: follow-up appointments after hospitalization within seven (7) and thirty (30) days);
2. Annual Mental Health Readmission Rate;
3. Initiation and Engagement of Newly Diagnosed Consumers with Substance Use Disorder (SUD);
4. Consumers Diagnosed with Schizophrenia and Antipsychotic Medication Adherence; and
5. Adherence of Antidepressant Medication Use for Consumers Diagnosed with Major Depression from Inpatient Hospitalization.

The ASO is developing intervention strategies designed to improve its performance compared to the CY16 baseline year. The period of intervention will be State FY 2019. The ASO must submit a preliminary report assessing the impact of the first six months of interventions to the Department by March 31, 2019. The final report is due to the Department by October 31, 2019. Should the ASO fall short of the annual targets, liquidated damages will be assessed

across each of the five criteria at the updated assessment of .1% not to exceed .5% of the total Contract.

**Collaborative Care Program Pilot**

Pursuant to page 78 of the 2016 JCR, the Department submitted a report regarding the opportunities to adopt a collaborative care model in the Medicaid Program.[2] Collaborative care is an evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. The report provided an overview of how the Collaborative Care model has been adopted in several states. The report further recognized that Collaborative Care has been identified as an official evidence-based practice by Substance Abuse and Mental Health Services Administration (SAMHSA) and identified by the Agency for Healthcare Research and Quality as a strong approach for integrating behavioral health treatment. Given these considerations, the Department recommended implementation of a one-year, limited pilot.

The Department has continued to study the Collaborative Care model and the feasibility of implementing a pilot since submitting its report. Studies that have implemented the collaborative care model have largely focused on use of the intervention for depression. Updated data and fiscal estimates associated with implementing a pilot for participants with depression are included below.

Table 1 shows the number and percentage of participants with a behavioral health diagnosis in HealthChoice, by MCO. Approximately 88,000 participants had a behavioral health MCO encounter in CY16. The four MCOs with the highest rates of participants with behavioral health encounters in CY 2016 were Jai Medical Systems, Maryland Physicians Care, Priority Partners, and UnitedHealthcare.

[2]2016 Joint Chairmen's Report on Collaborative Care Initiative, https://mmcp.health.maryland.gov/Documents/JCRs/2016/collaborativecareJCRfinal12-16.pdf.

**Table 1. Individuals in HealthChoice with Behavioral Health Services Billed to MCO, CY15-CY16**

| Last MCO | CY 2015 | | CY 2016 | |
|---|---|---|---|---|
| | Any Behavioral Health Encounter | | Any Behavioral Health Encounter | |
| | Number | Prevalence | Number | Prevalence |
| Amerigroup | 17,184 | 5.3% | 16,491 | 5.3% |
| Jai Medical Systems | 2,552 | 8.5% | 2,049 | 7.2% |
| Kaiser Permanente | 1,207 | 3.2% | 2,342 | 3.7% |
| Maryland Physicians Care | 18,028 | 7.4% | 19,216 | 7.9% |
| MedStar Family Choice | 5,217 | 5.7% | 6,403 | 6.8% |
| Priority Partners | 21,993 | 7.2% | 24,312 | 7.7% |
| University of Maryland Health Partners | 2,312 | 5.7% | 2,993 | 6.8% |
| UnitedHealthcare | 17,259 | 7.2% | 14,423 | 7.6% |
| **Total** | **85,752** | **6.6%** | **88,229** | **6.8%** |

The Institute for Clinical and Economic Review (ICER) conducted an analysis assessing the potential expenditures associated with integrating a collaborative care model into a Medicaid plan. In order to implement and sustain a collaborative care model, ICER estimates that organizations would need to invest between $3 per member per month (PMPM) for plans with a low prevalence of depression (3%) and $22 per member per month for plans with a high prevalence of depression (22.3%).[3]

Table 2 shows the number of HealthChoice participants in each MCO that have been diagnosed with depression who do not currently receive mental health services through Beacon Health Options and who would potentially be eligible to participate in a collaborative care model pilot. Overall, the number of HealthChoice participants with depression as a primary diagnosis decreased by 560 participants from 5,015 participants to 4,455 participants. The number of HealthChoice participants with depression as a secondary diagnosis decreased by 2,741 participants from 28,598 participants to 25,857 participants. The overall prevalence rate of

[3] Tice JA, Ollendorf DA, Reed SJ, Shore KK, Weissberg J, Pearson SD. Integrating Behavioral Health into Primary Care: a Technology Assessment (Final Report) Boston, MA: Institute for Clinical and Economic Review; 2015. https://icer-review.org/material/bhi-final-report/. Accessed December 8, 2017.

depression in the HealthChoice not receiving care through the ASO decreased from 2.6% to 2.3% from CY 2015 to CY 2016. Results across each MCO from CY 2015 to CY 2016 are varied, but UnitedHealthcare had the largest decrease in participants diagnosed with depression with a decrease of 532 participants with a primary diagnosis of depression and a decrease of 2,362 participants with a secondary diagnosis of depression.

**Table 2: Number of Participants Diagnosed with Depression (Excluding MH Visits Paid by Beacon Health Options), CY15-CY16**

| MCO | CY 2015 | | | CY 2016 | | |
|---|---|---|---|---|---|---|
| | Primary Diagnosis | Secondary Diagnosis | Prevalence | Primary Diagnosis | Secondary Diagnosis | Prevalence |
| Amerigroup | 767 | 4,963 | 1.8% | 778 | 4,564 | 1.7% |
| Jai Medical Systems | 112 | 1,139 | 4.2% | 72 | 983 | 3.7% |
| Kaiser Permanente | 66 | 301 | 1.0% | 78 | 340 | 0.7% |
| Maryland Physicians Care | 914 | 5,685 | 2.7% | 942 | 5,456 | 2.6% |
| MedStar Family Choice | 401 | 2,141 | 2.8% | 461 | 2,262 | 2.9% |
| Priority Partners | 1,200 | 6,580 | 2.6% | 1,118 | 6,853 | 2.5% |
| University of Maryland Health Partners | 164 | 971 | 2.8% | 147 | 943 | 2.5% |
| UnitedHealthcare | 1,391 | 6,818 | 3.4% | 859 | 4,456 | 2.8% |
| Total | 5,015 | 28,598 | 2.6% | 4,455 | 25,857 | 2.3% |

Based on the ICER estimates and a low prevalence rate of 3%, the Department assumes that the annual cost to implement a collaborative care pilot for a population of 200,000 would be $7.2M ($4.3M FF, $2.9M GF).[4]

Given these considerations, the Department intends to continue to explore the possibility of implementing the collaborative care model through a one-year limited pilot. However, in light of the fiscal impact of the model, moving forward with a limited pilot would require additional funding and the Department would need to obtain authority through an 1115 waiver.

[4] Note that actual prevalence of depression may be higher as a portion of cases may be undiagnosed. If actual prevalence is consistent with the high-end estimate from ICER (22.3%), costs projected would be substantially higher.

**Expansion of Health Home Program Provider Types**

Stakeholders have expressed an interest in expanding the provider types eligible to participate in the Chronic Health Home program to include Outpatient Mental Health Centers (OMHC) and other SUD programs. The Department is currently working on its third evaluation of the model, which will assess program outcomes through CY 2016. The Department anticipates publishing this report in late spring 2018.

As the Department learns more about the program's effectiveness, it will take expanding the Chronic Health Homes to include OMHCs and other SUD programs into consideration. However, the Department anticipates that expanding to new provider types could result in a substantial fiscal impact. In FY16, 104,587 individuals received services from 203 OMHCs.[5] Assuming 10% to 25% of individuals who received services at OMHCs in FY16 elected to enroll in the Health Home Program, the Department projects the fiscal impact would be an additional $11M ($6.6M FF, $4.4M GF) to $27M ($16M FF, $11M GF) annually.[6]

**Strategies to Improve the Sharing of Health Information**

Presently, efforts are underway on a statewide basis to continue to improve the sharing of behavioral health data through the State Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP). CRISP is developing an open source software application called 'Consent2Share', which will allow providers to access behavioral health data through CRISP if they are named in stored patient consents that comply with 42 C.F.R. Part 2. The Department supports the Maryland Health Care Commission's current rulemaking that will permit CRISP to implement the program.

## III. Conclusion and Next Steps

The Department remains committed to enhancing the integration of somatic and behavioral health services. In the coming months, the Department will continue to move forward with the planning and integration process internally with both the Behavioral Health Administration and the Medicaid agency for submission to CMS.

---

[5] The number of active OMHCs enrolled with the Maryland Medicaid Program has since grown to 273 as of November 2017.

[6] Fiscal estimate assumes providers bill for services 85% of the time, consistent with current trends. If overall enrollment increases were more substantial, projected costs would be higher.

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

The Hon. Edward J. Kasemeyer, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401–1991

The Hon. Maggie McIntosh, Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401–1991

**Re: 2017 Joint Chairmen's Report (p. 79)—Report on Combining the Various Behavioral Health Authorities**

Dear Chairs Kasemeyer and McIntosh:

Pursuant to the 2017 Joint Chairmen's Report (p. 79), the Maryland Department of Health respectfully submits the attached report detailing the feasibility, costs, and benefits of merging the core service agencies with the local addictions authorities in various jurisdictions.

This report provides an informative step in the ongoing work to strategically integrate behavioral health systems management within the Behavioral Health Administration (BHA) and in local jurisdictions. While the BHA provided overall guidance, the methodology, analysis and content in this report were developed by an independent consulting firm with experience in working with multiple stakeholders collaborating on assessment, design and implementation of systems change.

If you have any questions regarding this report, please contact Webster Ye, Deputy Chief of Staff, at (410) 767–6480 or webster.ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Webster Ye, Director, MDH Deputy Chief of Staff
Dr. Barbara J. Bazron, MDH Deputy Secretary for BHA
Sarah Albert

# BEHAVIORAL HEALTH INTEGRATION: CHALLENGE OF INNOVATION

## A REPORT ON COMBINING CSAs WITH LAAs IN VARIOUS JURISDICTIONS

NOVEMBER 1, 2017

## Table of Contents

# INTRODUCTION

## Request from the General Assembly

Reflecting the vision to provide "improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care" set forth in the FY 2017 Behavioral Health Plan, the 2017 Maryland State budget calls for the Behavioral Health Administration (BHA) to submit "a report on the feasibility, costs, and benefits of merging the core service agencies with the local addictions authorities." As part of that budget provision, the General Assembly reaffirmed the "*policy imperative to fully integrate behavioral health services in the State.*"[1]

In response to that request, this report has been developed by the Maryland Department of Health (MDH) regarding the feasibility, costs, and benefits of merging the core service agencies with the local addictions authorities. The following sections of the report provide:

1. Information on how the experience of those counties with merged behavioral health authorities differ from the counties where these authorities remain separate;
2. Information on grants that each recipient entity receives;
3. Information on how grants are divided among administrative and treatment costs; and
4. Recommendations on whether or not it would be beneficial to the oversight and efficiency of the public behavioral health system to combine core service agencies and local addictions authorities in each jurisdiction where it is not already so.

In line with the policy imperative to fully integrate behavioral health in Maryland, the BHA has been moving toward strategic integration of behavioral health, including state administrative functions, funding streams, and local systems management. Insights from the analysis in this report inform these BHA activities, and confirm the assumption that an integrated approach to local oversight and accountability appears to be more efficient and effective than separate local oversight for mental health and substance use – e.g., a greater percentage of funding goes to treatment and smaller percentage to administrative overhead in local jurisdictions with an established Local Behavioral Health Authority (LBHA). LBHAs indicate having deeper involvement in ensuring coordination among providers and addressing issues such as network adequacy and quality improvement. Recommendations in this report reflect themes from interviews with leaders from local jurisdictions and statewide groups, and emphasize that behavioral health system integration is complex and still in transition at both the state and local levels. Everyone has more work to do. Completing this transition to integrated management and oversight will take a few years and require continued strategic and operational planning, clear two-way communication, technical guidance and informational support, and adaptation by public and private organizations in local jurisdictions and at the state level.

[1] *Report on the Fiscal 2018 State Operating Budget (HB150) and the State Capital Budget (HB151) and Related Recommendations*, page 79, Joint Chairmen's Report – Operating Budget April 2017.

## Terminology and Assumptions

For the purposes and in the context of this report, several key terms are defined below.

**Core Service Agency (CSA):**

Local mental health authorities responsible for planning, managing, and monitoring publicly-funded mental health treatment and rehabilitation services for people with mental illness in a local jurisdiction. CSAs exist under the authority of the Secretary of MDH and are agents of the local jurisdiction government, which approves their organizational structure.[2]

**Jurisdiction:**

The 24 local regions in Maryland is comprised of 23 counties plus Baltimore City.

**Local Addictions Authority (LAA):**

The designated authority in the local jurisdiction, or multiple local jurisdictions, is responsible for planning, managing, and monitoring publicly-funded treatment and rehabilitation services for people with substance use and addiction-related needs in a local jurisdiction.[3] LAAs collaborate with other human service agencies to promote comprehensive services for individuals with substance use disorders who have multiple needs.[4]

**Local Behavioral Health Authority (LBHA):**

The designated authority in a local jurisdiction, or multiple local jurisdictions, that is responsible for planning, managing, and monitoring publicly funded mental health, substance use related, and addictive disorder services.[5] As of September 2017, LBHAs have been established in 11 of the 24 local jurisdictions. Some LBHAs were recently formed so for FY2017 they received mental health and substance use funding in separate streams. LBHAs that have been in existence for a longer time period were funded in FY2017 as a single entity receiving combined funds for mental health and

[2] Maryland Behavioral Health Administration. https://bha.health.maryland.gov/Pages/CSA-Resources.aspx Accessed September 2017.
[3] Maryland Behavioral Health Administration. https://bha.health.maryland.gov/Documents/LAA.pdf Accessed Sept2017
[4] Maryland Association of Behavioral Health Authorities. https://www.marylandbehavioralhealth.org/ Accessed Sept2017.
[5] Maryland Behavioral Health Administration. https://health.maryland.gov/regs/Pages/10-63-01-10-63-06-Behavioral-Health-Regulations-(.aspx Accessed September 2017.

substance use. For this report, funds received by LBHAs have been separated into CSA and LAA categories to enable the financial analysis as requested by the General Assembly.

**Service Integration:**

The state of being in which a single entity in a local jurisdiction is the single point of contact for funding from BHA, which is responsible for providing systems management oversight to ensure network adequacy and performance of the local behavioral health system.

**Systems Management:**

The process of planning, management and accountability for the overall quality and patient outcomes from the local behavioral health system. It involves serving in a neutral capacity to oversee the entire behavioral health system in the local jurisdiction, distinct from directly providing services or operating treatment programs.

The following assumptions are important to the analysis in this report.

**Intent is to Forge a Pathway to Enable Increased Alignment and Coordination.**

Consistent with General Assembly's reaffirmation of the *"policy imperative to fully integrate behavioral health services in the State,"*[6] this analysis was conducted to answer questions posed by the General Assembly while gathering insights to inform the work that is already in process to plan, facilitate and support local jurisdictions' efforts to move toward integration of behavioral health systems management.

**Integrating Behavioral Health Systems Management Funding and Accountability Is In Process.**

Much has been accomplished in the commitment of MDH to being more strategic about funding behavioral health services using a comprehensive, integrated approach. This analysis is a snapshot in time happening the midst of this complex transition, with changes occurring in funding amounts and methods, such as moving substance use funding from grants to a fee-for-service system.

[6] *Report on the Fiscal 2018 State Operating Budget (HB150) and the State Capital Budget (HB151) and Related Recommendations*, page 79, Joint Chairmen's Report – Operating Budget April 2017.

**Emphasis on Integration of Local Behavioral Health Systems Management.**

The focus of local behavioral health integration is on the systems management functions, which is related to but not the same as integrating treatment and/or service provided directly to clients at risk of or with serious mental health, substance use or other behavioral health issues.

**Flexibility in Local Approaches is Essential.**

Recognizing the variety in structures that exist within the local behavioral health landscape, and the unique characteristics of each local region in terms of population base, geography, and organizational structures, histories and relationships, there is no single approach to integrating behavioral health systems management that will work for every region. Some local jurisdictions are clear that the work must be led by their health department or other local government agency, others are committed to it being done by a private non-profit organization, and others may determine that the best configuration may be a combination of public and private agencies.

**Integration is Best Assessed Along a Continuum Rather than as "Merged vs. Separate."**

Language used by the General Assembly refers to "merged or combined" versus "separate" CSAs and LAAs; however, the variety of local structures and agreements between public and/or non-profit agencies prevents a simple two category grouping of local jurisdictions. Instead, this analysis recognizes that integration is a process that involves alignment of various attributes, including but not limited to structural, contractual and financial, procedural, and cultural.

## Logic Model and Limitations

Under the guidance of leaders of BHA, the logic model illustrated in Figure 1 below was designed and used to develop this report.

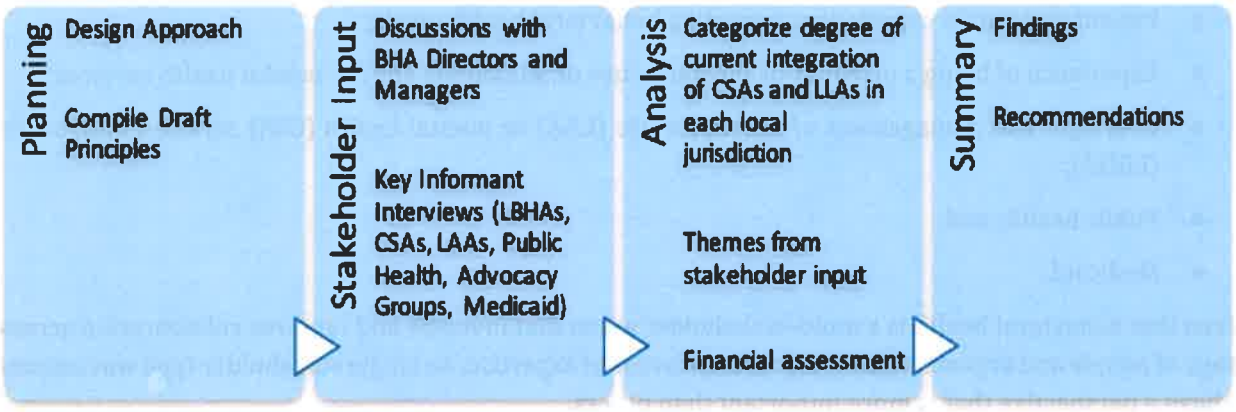



*Figure 1: Logic Model Used in Development of this Report*

After the overall approach was identified, planning involved individual and group discussions with the Deputy Secretary, directors, and program managers of BHA to share information, collect guidance, identify external stakeholders to provide input, develop a guide for gathering insights from others, and compile concepts to be reflected in the draft Principles for Integration. Eighteen individuals were interviewed (see Attachment A) regarding their perspectives on the questions addressed in this report, in addition to a set of rough draft Principles for Integration. Analysis began with an assessment of information about the current structures of CSAs and LAAs in each of the 24 jurisdictions to determine their status in relation to a three-stage continuum of integration. This information was then applied to the qualitative information collected during the interviews and the quantitative financial information provided by the BHA to conduct the analyses and identify findings and recommendations.

Regarding limitations, it is important to note that the behavioral health environment at the local, state, and national levels is undergoing major transitions in terms of expectations for greater integration across mental health and substance use services at the treatment and systems management levels, in addition to changes regarding the financing structures and approaches. Thus, this report is a snapshot in time during a transition to a more strategic approach to funding. It reflects the most current structural and financial information available as of the early fall 2017. Given that this is the first time conducting an analysis of this type, the information contained in this report could be used as a baseline for future comparison.

In addition, given the range of topics, situations and human needs within the behavioral health community, it is impossible to gather perspectives from all of the stakeholders who potentially have an interest in the issues addressed in this report. However, care was taken to ensure that interviewees generally represent

the approximate diversity of the primary stakeholders at the local and state levels. The interviewees brought to the analysis their expertise in a range of areas, including but not limited to:

- Unique characteristics of local counties and regions;
- Patient and family experiences regarding behavioral health needs;
- Experience of being a provider of substance use or addictions and/or mental health services;
- Oversight and management of substance use (LAA) or mental health (CSA) services, and/or both (LBHA);
- Public health; and,
- Medicaid.

Given that behavioral health is a multi-stakeholder arena that involves and requires collaboration across a range of people and organizations with different areas of expertise, no single stakeholder type was assumed to have a perspective that is more important than others.

## Qualitative Analysis: Experience in Merged vs. Separate Authorities

### Categorizing Merged versus Separate CSA and LAAs in Local Jurisdictions

Currently, as described in the assumptions above, many aspects of the administration and oversight of mental health, substance use and addiction services have been or are being merged or integrated at the state level under BHA. Even with these changes, a number of mental health and substance use or addictions functions still remain separate. This is due to a number of factors such as separate funding streams from the federal government, and distinct differences in policies, laws and regulations affecting mental health (CSAs) and substance use (LAAs).

The separate sets of federal and state rules, regulations, and financing structures drive many of the decisions and actions within local jurisdictions. In addition, as noted earlier, integration of CSAs and LAA is not a matter of being separate (no integration at all) or merged (completely integrated): Even local jurisdictions known for having a merged LBHA for quite some time still consider themselves evolving toward full integration of the CSA and LAA system management functions.

Across Maryland, the degree of integration of CSAs and LAAs from one local region to another varies greatly, and, in some local areas, perspectives appear to differ regarding the degree to which behavioral health systems management integration is in place. In addition, each local jurisdiction has their own mix of organization types, contractual agreements, collaborative relationships and approaches to achieving

alignment and coordination for behavioral health systems management. For example, CSAs can exist in a number of forms: some are units of local government (e.g., health department), others are quasi-public authorities, and some are private, non-profit corporations. The specific model for CSAs and LAAs in any given local jurisdiction typically emerges from a local process that has involved input from patients and their family members, plus other community members, providers, policy makers, and advocates.[7]

To conduct the analysis reflected in this report, the structures of local jurisdictions were assessed then grouped into three stages along the continuum of integration. This approach recognizes the varying degrees and ways in which integration of administrative oversight functions has already occurred or is currently in transition within local jurisdictions. Viewing integration status as being along a continuum, even within each grouping, is particularly important for local jurisdictions in which the CSA and LAA are working on integrating key aspects of their functions yet, on paper, may appear to be completely separate.

Figure 2, below, illustrates the three levels of integration used in this analysis.

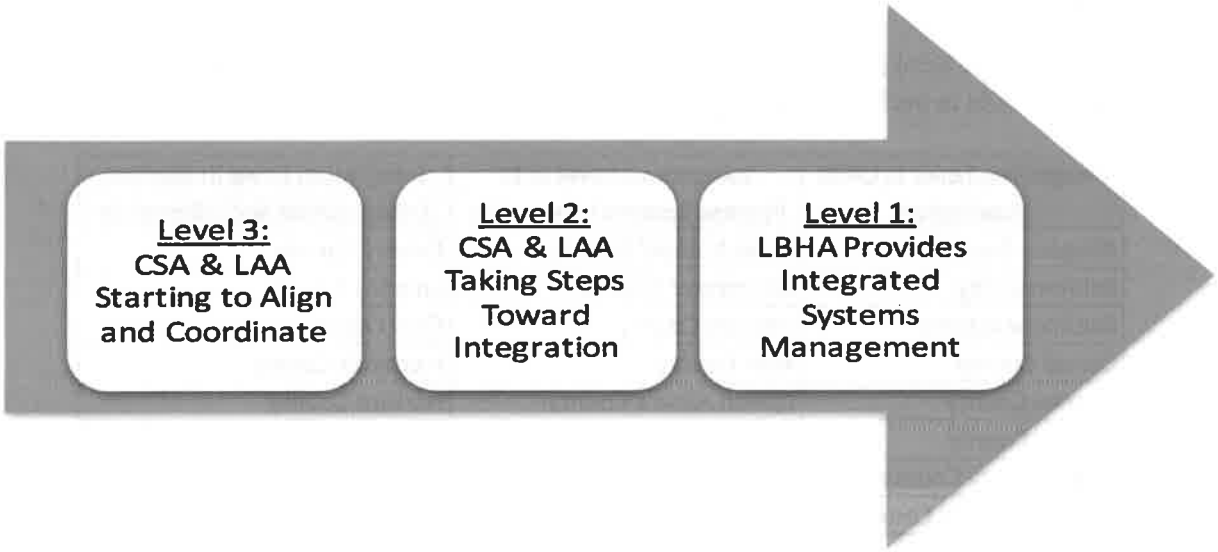



*Figure 2: Levels of Integration on a Continuum*

All 24 local jurisdictions have begun some level of alignment and coordination across mental health (CSA) and substance use (LAA) systems management functions, even if only as informal coordination and collaboration. The following factors were used to group the 24 local jurisdictions into three levels of integration:

[7] Maryland Behavioral Health Administration, 2017. https://bha.health.maryland.gov/Pages/CSA-Resources.aspx Accessed September 2017.

- Level 1: The local jurisdiction has established a LBHA which is responsible for the financial oversight and management at the systems level for all mental health (CSA), substance use (LAA) and co-occurring disorders, as of the end of September 2017.
- Level 2: There is indication that the CSA and the LAA in the local jurisdiction have one or more shared aspects of systems management or other formal collaboration. This may be evidenced by the CSA and the LAA being operated out of the same organization and/or being overseen by the same director or manager. These jurisdictions are moving toward cross-service coordination and the integration of systems management functions.
- Level 3: All other local jurisdictions are in the Level 3 category, as the experiences described in interviews with local and state behavioral health leaders note the growth in coordination and alignment occurring across CSAs and LAAs. All interviewees noted the importance of moving toward greater integration across CSAs and LAAs. These entities are at the beginning of the service integration process.

Figure 3 below lists the local jurisdictions grouped by where they are on the continuum of integration. For a list of CSAs and LAAs in each local jurisdiction, see Attachment B.

| Integration Level 1: LBHA Established | Integration Level 2: In Process Toward Integration | Integration Level 3: Starting Coordination and Alignment |
|---|---|---|
| Allegany County | Anne Arundel County | Calvert County |
| Baltimore City | Dorchester County | Caroline County |
| Baltimore County | Howard County | Cecil County |
| Carroll County | Kent County | Frederick County |
| Charles County | Queen Anne's County | Harford County |
| Garrett County | | Somerset County |
| Montgomery County | | Talbot County |
| Prince George's County | | Washington County |
| St. Mary's County | | |
| Wicomico County | | |
| Worcester County | | |

*Figure 3: Local jurisdictions grouped by Level of Integration as of September 2017*

Some of the local jurisdictions in the Level 1 group recently formed an LBHA, so they received mental health and substance use FY 2017 funding as separate streams to the CSA and LAA, respectively. LBHAS that have been in existence for longer were funded as a single LBHA entity in FY 2017, receiving combined funds for mental health and substance use. As noted in the financial section of this report, funding amounts received by more established LBHAs have been separated into the appropriate CSA or LAA category to enable the analysis as requested by the General Assembly.

## Challenges of Innovation: Differences in Experience Among Local Jurisdictions

Based on insights from discussions and interviews with leaders from LBHAs, CSAs, LAAs and other stakeholder groups, the following themes emerged regarding the differences in experiences of local jurisdictions in terms of integrated behavioral health systems management.

### A. Focus on meeting the needs of individuals is paramount.

It is clear that all jurisdictions are committed to a behavioral health system that is client-centered and addresses the needs of the whole person.

1. Many noted that this is not easy to achieve for a variety of reasons, especially because much of behavioral health remains in siloes for mental health versus addictions, in areas including but not limited to funding streams, reporting requirements, accreditation or certification standards, treatment modalities, data sources, regulations, and culture. Those separate 'stove pipes' impact the ability to bring it all together seamlessly to serve people in the local region who are at risk of or have serious mental illnesses, substance use or addictions needs.

2. Several LBHAs (Level 1) expressed that, as they achieve greater integration, they are better equipped to address the needs of the entire person due to taking a more comprehensive approach to behavioral health in contrast to maintaining separation between mental health and substance use. That being said, there are still challenges with reducing disparities, ensuring clear communication, and the practical implementation of the ideal 'no wrong door' approach.

### B. Relationships are essential.

There is a shared recognition that local leaders know their own community, plus the local mental health, substance use and/or behavioral health providers, best.

1. All recognize the essential nature of relationships, but the types of relationships appear to differ by degree of systems management integration.

2. LBHAs (Level 1) describe their relationships in broader terms, noting the importance of connections with behavioral health providers, health care providers and community service agencies across their local area, in addition to relationships with leaders at the state level and with their peers. Those with LBHAs are described as being the local jurisdictions that tend to "show up and engage more often."

3. The local jurisdictions that are at the early stages of integration (Level 3) are focused on relationships in their local jurisdiction and with peers. Personal connections – many of which are long-standing – are the primary means of coordination and alignment among CSAs and LAAs. One called this approach a form of "self-integration." Another noted that CSAs and LAAs that are not visible beyond their local jurisdiction may have difficulty getting the information and resources that they need.

## C. Funding structures and incentives in behavioral health affect integration.

While financing from the BHA has been modified to directly support efforts to integrate behavioral health systems management, the federal government and other funding sources continue to have separate funding and program management requirements for mental health versus substance use services.

1. While many noted the management and oversight challenges due to the separate funding streams, the financial support that BHA has provided to achieve greater integration at the local level has been important for the progress made thus far. Some of the interviewees went further to suggest that even stronger financial incentives could be used to reward success in increasing the use of evidence-based practices, assisting providers in achieving certification or accreditation, and investing more in planning, information technology, and data-related infrastructure.

2. LBHAs (Level 1) appear to be more advanced in achieving integration regardless of the separate funding, although the views on the implications of the separate funding streams are not unanimous. One said, "We have 27 different funding streams from the State. We work with what's possible and have been able to integrate in many areas, even with separated funding." In contrast, another noted that "managing separate funding streams for mental health and for substances use is a huge issue."

3. Other jurisdictions in process or just starting (Level 2 and 3) in systems management integration view the separate funding streams as a major barrier to integration.

## D. Culture within the behavioral health community matters.

There is a shared recognition of deeply held cultural differences between mental health (CSAs) and substance use (LAAs) managers, providers and patients or clients and family members.

1. Based on interviewee comments, certain differences in the culture of mental health versus substance use are expected to continue. Examples include differences in: provider training; the degree to which providers are prepared to meet performance expectations and clinical efficacy standards; and the focus on self-help and recovery – elements essential to person-centered behavioral health care. An interviewee also observed that not all clients have co-occurring needs; some patients are concerned being grouped into behavioral health when their needs may be solely mental health or addiction.

2. LBHAs (Level 1) appear to be more advanced in bridging cultural differences, taking more formal approaches to change management to strategically address integrating cultures as appropriate. One LBHA emphasized that having people on their team with mental health provider experience and others with substance use provider experience is essential, as each bring skills to the table. Others described the value of cross-training and the need for LBHA team members to learn from each other.

3. Entities in the midst of systems management integration (Level 2) indicate that they are experiencing difficulties bringing these very different groups together.

## E. Data needs increase with greater systems management experience.

All recognize the importance of data analysis for effective systems management.

1. LBHAs (Level 1) and jurisdictions in process (Level 2) experience challenges in getting the data they need to support the oversight and accountability functions of the LBHA, or CSA and LAA. Some noted that the available data is improving, such as data integration being done by the Beacon Health Options the Administrative Service Organization (ASO). However, more progress is needed in areas such as: moving from paper to electronic recordkeeping; universal access to clients' consent for release of information; integrated financial data and billing codes for behavioral health assessments; and substance use data to inform systems management decisions being made by public health departments that also provide treatment or services for addiction.

2. LBHAs (Level 1) also mentioned the desire for access to data that supports more comprehensive behavioral health system planning. Examples include data from or about: Medicaid and other types of coverage, available social support services for children and adolescents, the Emergency Medical System (EMS), CRISP – the Chesapeake Regional Information System for our Patients (health information exchange system), and disparities and equity. The deeper the involvement in data-driven decision making and accountability for the entire system, the more acute the concern is regarding the difficulty of accessing relevant and useful data.

3. Jurisdictions that are starting the process of alignment (Level 3), value the data they are beginning to receive and find it useful, but may not have staff with sufficient data analytic capabilities to fully utilize that data for planning and decision-making. More than one interviewee observed that changes made within local jurisdictions to separate systems management from service delivery created barriers to accessing substance use data.

## F. Need to further define the parameters to avoid Conflict of Interest.

While the BHA policy regarding Conflict of Interest was not addressed in any of the interview questions, the topic was independently raised by every local jurisdiction representative interviewed. The expectation set forth in the Conflict of Interest policy is that the oversight role of systems management is separate from the role of delivering behavioral health treatment or services. This is intended to ensure that the entity charged with oversight of quality and accountability for outcomes is able to take a neutral view regarding all service delivery within their jurisdiction.

1. All interviewees want to avoid conflict of interest and are aware of the practical impact of the Conflict of Interest policy. Independent providers in the behavioral health community agree with the need for the policy. Where local jurisdictions appear to differ in their views is in the degree to which they believe that organizational structures, functions and provider network adequacy must be disrupted or changed

to ensure that there is no conflict of interest. MDH is working with the Attorney General's Office to bring greater clarity in response to the issues raised by the Conflict of Interest policy.

2. LBHAs (Level 1) more consistently approach the issue with ideas for how conflict can be avoided while still achieving fully integrated systems management. One observed that an LBHA is responsible for the effectiveness of the entire local behavioral health system, so there is little incentive to create an uneven playing field among certain providers. Another noted that "adequate firewalls can solve the problem." As noted earlier, some commented that actions taken in response to the current policy have created barriers to accessing data that is essential for effective system management decision-making.

3. CSA or LAAs in less integrated jurisdictions (Level 2 and 3) describe changes that have been made in response to the conflict of interest policies that resulted in more complexity to ensure clear separation between service delivery and administrative oversight. For example, some local agencies have signaled that they plan to cancel existing agreements to align and coordinate certain behavioral health services, while others entered into new contracts that moved certain system management functions completely outside of their own local jurisdictions.

4. Several noted that the total structural or organizational separation of oversight from service delivery may not be possible for LBHAs, CSAs or LAAs in rural jurisdictions in which the number of mental health, substance use or behavioral health providers is insufficient to meet local community needs.

## G. Integration takes time, creates complexity, and increases desire for clarity and flexibility.

All appear to understand the need for integration of behavioral health systems management, regardless of where they currently are in the process. Aspects of the behavioral health system are changing every year, and local jurisdictions are working to adapt as best they can in ways that work well for the unique characteristics of their local area. The result is a behavioral health environment – locally and statewide – that is currently complex and challenging.

1. Several LBHAs (Level 1) described integration as a multi-faceted evolution that takes time, sometimes years. An interviewee explained it this way: "Integration is more than just structural. It must address policy, practice, infrastructure and human capital." Taking on the accountability for planning and outcomes is no small task. As a local entity representative noted, "Behavioral health systems oversight is a sophisticated and complicated role."

2. As such, all expressed a desire for greater clarity from the State BHA in one or more specific areas to define the framework and build the policy and practice environment, then allow flexibility for local jurisdictions to make decisions that work best for their local circumstances. Examples given for where greater clarity is desired include: policies, financial structures, and outcome metrics, evidence-based standards and protocols (especially for substance use treatment), and the overall strategic direction for behavioral health in Maryland.

3. Less integrated entities (Level 2 or 3) and other stakeholders also asked for information about the role of CSAs, LAAs, LBHAs, public health departments, Beacon Health Options ASO and the State BHA. One put it this way: "For each of the entities involved in behavioral health oversight, where do they align, overlap, and differ?"

Finally, while all of the local CSAs and LAAs continue to work on improving the integration of systems management in some way, local jurisdictions with LBHAs in place (Level 1) generally appear to be more involved in the following:

- Taking a combined approach to strategic planning to assess the behavioral health needs across their entire local jurisdiction.
- Providing training and support for the full range of providers involved in mental health and substance use or addictions services to improve quality, achieve accreditation or certification, and work more effectively with each other as a local behavioral health system.
- Cultivating deeper relationships and stronger coordination with providers in other aspects of the health care system (hospitals, primary and specialty care) in addition to community service providers or agencies that are essential partners in addressing upstream social determinants of health, such as housing, schools, police and courts.

## Financial Analysis: Merged vs. Separate Authorities

### Funding to Local Jurisdictions Reflects Complex Structure of Financing

The overall behavioral health system in Maryland is evolving toward greater integration of systems management, including funding mechanisms. Local jurisdictions that recently formed an LBHA received separate FY 2017 funding for mental health and for substance use, sent to their CSA and LAA, respectively. LBHAS that have existed for a year or longer were funded as an LBHA in FY 2017, receiving a single check that contains funds for mental health and substance use. To be responsive to the questions from the General Assembly, the analysis of funding received by local jurisdictions, whether or not they have an established LBHA, is grouped into two categories: mental health (CSA) and substance use (LAA).

Much has already been accomplished in integrating funding for mental health services and substance use services, with changes in funding methods, amounts and oversight accountability. At the same time, the transition to a more strategic approach to funding behavioral health in Maryland is still evolving.

- The mental health system moved from a grants approach to a fee-for-service system in 1997, using an Administrative Services Organization (ASO) contract structure. Then, in 2015, Medicaid funding for mental health services was separated from non Medicaid funding and moved to the Beacon Health Options ASO. Under this integration model, the Beacon Health Options ASO pays for

behavioral health services using a fee-for-service system while managing behavioral health services for individuals covered by Medicaid and for certain people who are uninsured. The goal is to create a coordinated and seamless system for individuals while improving their clinical outcomes, recovery, and resiliency.

- For substance use, the system funding has largely been grant-based through Medicaid Managed Care Organizations (MCOs); however, substance use funding is being transitioned out of Medicaid MCOs to a fee-for-service approach under the Beacon Health Options ASO. This began in FY 2015 and is happening in phases. Substance use ambulatory services have been moved to the Beacon Health Options ASO, with eight jurisdictions transitioning on July 1, 2016, and others on January 1, 2017. Residential services for substance use began to change to fee-for-service, starting with certain adult residential services[8] on July 1, 2017. Specialty residential services for pregnant women and women with children, as well as 8-507 Forensic Residential services, will transition to fee-for-service through the Beacon Health Options ASO on January 1, 2018. Finally, on January 1, 2019, funding for halfway houses[9] will move to fee-for-service.

Where possible, the State BHA is working on integrating financial procedures to create a consistent approach for behavioral health but the transition to a more strategic approach to funding takes time and may not result in a wholesale shift from entirely 'separate' to completely 'merged' local entities, as described earlier. Additional considerations regarding the financial analysis in this report include:

- The financial analysis in this report is a snapshot in time, focusing on funding in Fiscal Year 2017 only. This ensures as much clarity as possible in the comparisons. However, even within the FY2017 data, funding amounts may be skewed because of funding transitions that did not apply to all local jurisdictions at the same time, as described above. For the same reason, this report does not compare funding levels across multiple years. Regardless, the analysis in this report provides insights that are directionally correct.
- Many local jurisdictions receive funding to provide mental health and/or substance use services in multiple jurisdictions or statewide. As needed, funding received by a local jurisdiction to administer a multiple jurisdiction or statewide program has been excluded from the analysis to enable consistent comparison of administrative and treatment costs for LAA and CSA activities in their local region.
- In seven counties, mental health services are administered by a CSA that services multiple jurisdictions. Mid-Shore Behavioral Health, Inc. is the CSA serving Caroline, Dorchester, Kent, Queen Anne and Talbot counties. In Wicomico and Somerset counties, a single CSA serves both regions. For purposes of analysis, funding to these CSAs has been divided among all counties in their service area.

[8] ASAM Level of Care services 3.3, 3.5. 3.7 and 3.7D
[9] ASAM level of care 3.1 Services

- Some CSAs and LAAs may receive funding from sources beyond BHA, such as local county or city government, foundations or private organizations. The analysis in this report only reflects funding provided to CSAs and LAAs through the Maryland BHA.
- In one or more local jurisdictions, public health departments have received funding for certain behavioral health services, separate from the funding to the CSA and/or LAA. Such funding is not included in this analysis.
- Federal funding for behavioral health flows from the Substance Abuse and Mental Health Services Administration (SAMHSA) to states via block grants focused on mental health and on substance use. Each of these block grants comes with unique reporting and program requirements which must be followed by the State of Maryland which, in turn, makes these separate mental health and substance use awards to the local jurisdictions. Therefore, it is not surprising that CSAs and LAAs might use different approaches for financial tracking and accounting. For example, funding for LAAs has been historically subject to fewer guidelines to provide maximum flexibility for local jurisdictions to meet ongoing and crisis-related needs of their region. This approach is transitioning, however, to bring LAA accountability in line with the community-based oversight of CSAs.

## Grants Received by Merged vs. Separate Entities

The funding amounts received by CSAs range from about $440k to more than $14 million, and funding to LAAs range from roughly $530k to $36 million. However, to enable appropriate comparison, funding amounts should be adjusted to reflect the differences in population size, level of need, or other relevant factors. While the General Assembly's request for this analysis refers to grants to CSAs (mental health) and LAAs (substance use), CSAs have received funding through a fee-for-service system since 1997 and LAAs are in the midst of transitioning from grants to fee-for-service funding, as described above.

For purposes of this analysis, the absolute funding amounts from FY2017 have been normalized to per-person rates, using estimates of the number of people served by CSAs and LAAs in FY2017 in each local jurisdiction. Note that the estimates of the number of people served are based on data from claims paid for mental health and substance use services through 8/31/2017, from all coverage types. While the total service rates are unduplicated, this FY2017 data is not final as providers have 12 months from time of service in which to submit a claim for payment. Therefore, this analysis assumes underreporting in these service rate estimates; however, the difference in the estimated service rates compared to the actual service rates is likely to be relatively consistent from one jurisdiction to another.

The per person funding level was calculated by taking the total FY2017 funding for CSA and LAA in each jurisdiction and dividing it by the number of people served in FY2017. The chart in Figure 5 below shows the estimated total CSA and LAA funding per person in each local jurisdiction in FY2017, arrayed from high to low. The colors represent the Integration Level for each local jurisdiction: Level 1 in green; Level 2 in blue; and, Level 3 in orange.

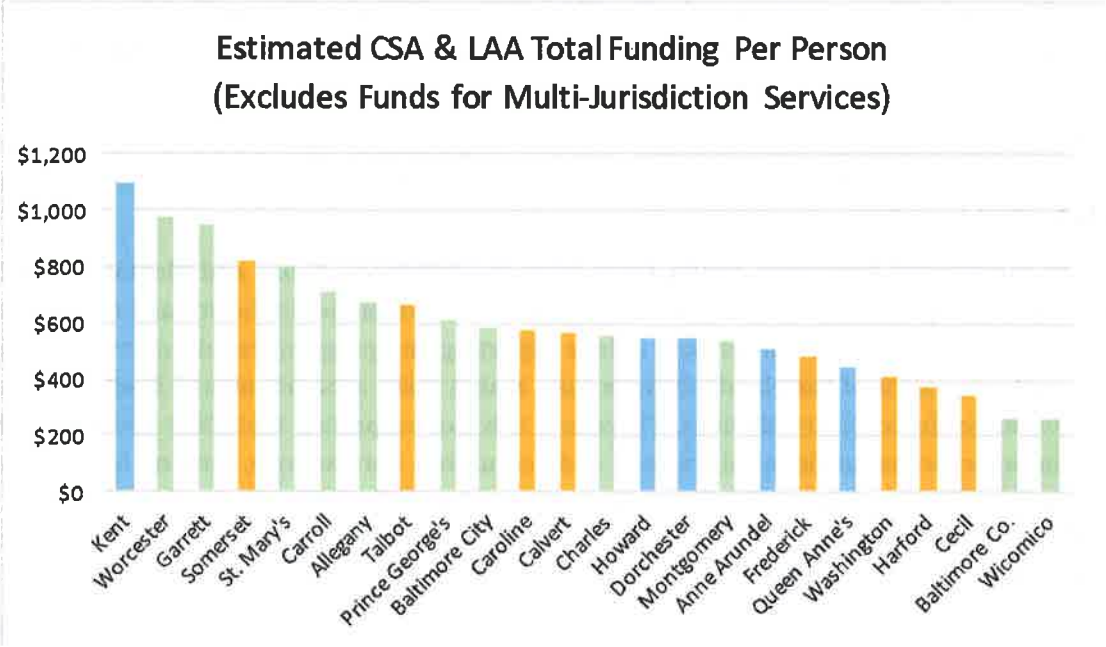



*Figure 5: Estimated Per Person Total Funding, Color Coded by Level of Integration (Green: LBHA; Blue: Mid-Process; Orange: Starting)*

There appears to be no clear pattern of total funding differences across organizations at different stages in the transition toward integration. This may indicate that moving from 'separate' to 'merged' is more complicated than simply reducing duplication of effort therefore reducing the total cost per person served in a local jurisdiction. The differences in total funding per person may stem from unique characteristics or conditions in local jurisdictions that increase the difficulty of serving clients or the acuity of client needs.

Differences in the funding levels observed above may reflect variation in the scope of functions performed in local jurisdictions that are more advanced in their systems management integration, as they may have the ability to leverage resources in ways that cannot be done by CSAs or LAAs that are not as far along on the continuum toward integration. Given their role, LBHAs may be organizing resources in ways that allow for deeper involvement in system planning, management, oversight and accountability, and focusing available resources to address the greatest behavioral health needs in the local region. One interviewee described it this way: "Rather than thinking of the financial merger as solely a matter of economies of scale, there is also a realignment of resources evident in how some of the LBHAs are organizationally structured." This distinction is evident when assessing whether there appears to be an impact of integration on funding spent on administration versus treatment.

For a list of the CSA and LAA grants amounts from the BHA, see Attachment C. The estimated number of clients served by the CSA and LAA in each local jurisdiction in FY2017 is listed in Attachment D.

## Administrative vs. Treatment Costs for Merged vs. Separate Entities

In jurisdictions with more integrated approaches to behavioral health systems management, it appears that economies of scale can be found from reduced duplication of effort, earlier lower-cost interventions that result from effective entry of individuals and families into the system ('no wrong door') and better coordination among providers. However, better systems management also involves activities that may not be being done by local CSAs and LAA that operate separately, such as data analytics to drive planning and informed decision-making, better coordination among behavioral health providers and with others in the health care system and with other entities – such as housing, K-12 education, police and justice system – that can have an upstream impact on reducing mental health and substance use problems.

Comparing total funding in FY2017 for treatment cost or services against administrative costs within local jurisdictions, grouped by level of integration, reveals interesting insights. For example, as seen in Figure 6 below, the total administrative costs for Level 1 jurisdictions (LBHAs) and Level 2 jurisdictions (In Process) appear to be lower than the administrative costs for CSAs and LAAs operating in jurisdictions that are just beginning to align and coordinate.

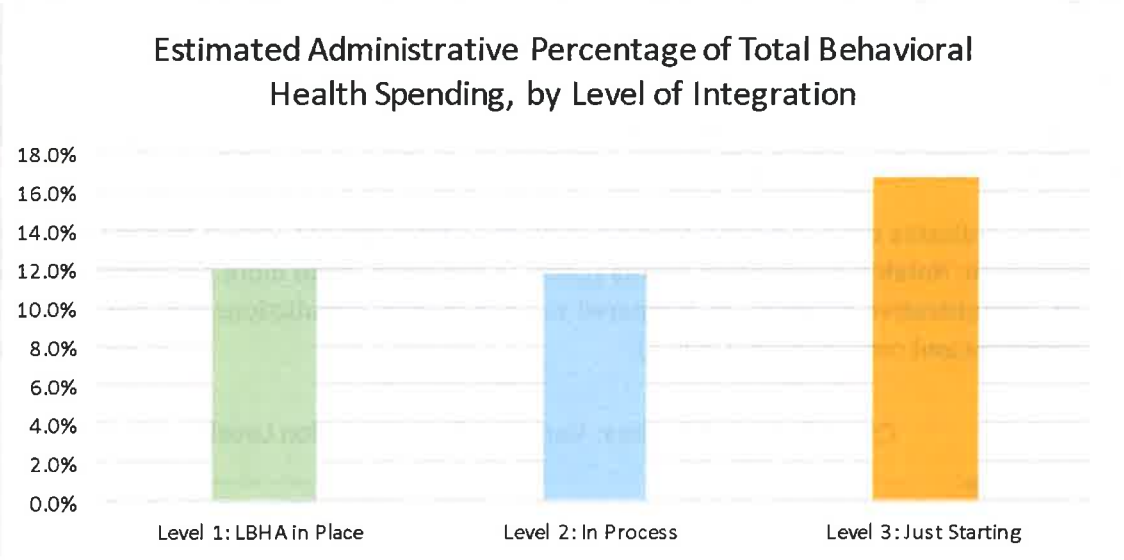



*Figure 6: Estimated Administrative Cost Percentage of Total Behavioral Health Funding, by Level of Integration*

The lower administrative costs may be due to alignment of expectations and certain activities across the LAA and CSA in local regions with LBHAs, resulting in economies of scale. For example, as one interviewee described, if the infrastructure for a crisis hotline has been developed to serve the mental health community, adding substance use services to this existing hotline infrastructure is more cost-effective than developing a separate hotline.

That said, within each of the integration levels there is notable variation in the percentage of funding for administrative activities, as illustrated in Figure 7 below. Such differences among local jurisdictions is not surprising, considering that the behavioral health system is transitioning to a more strategic approach to

funding, and all local jurisdictions are at various stages on the integration continuum, working through complex processes associated with integrating systems management, as described above.

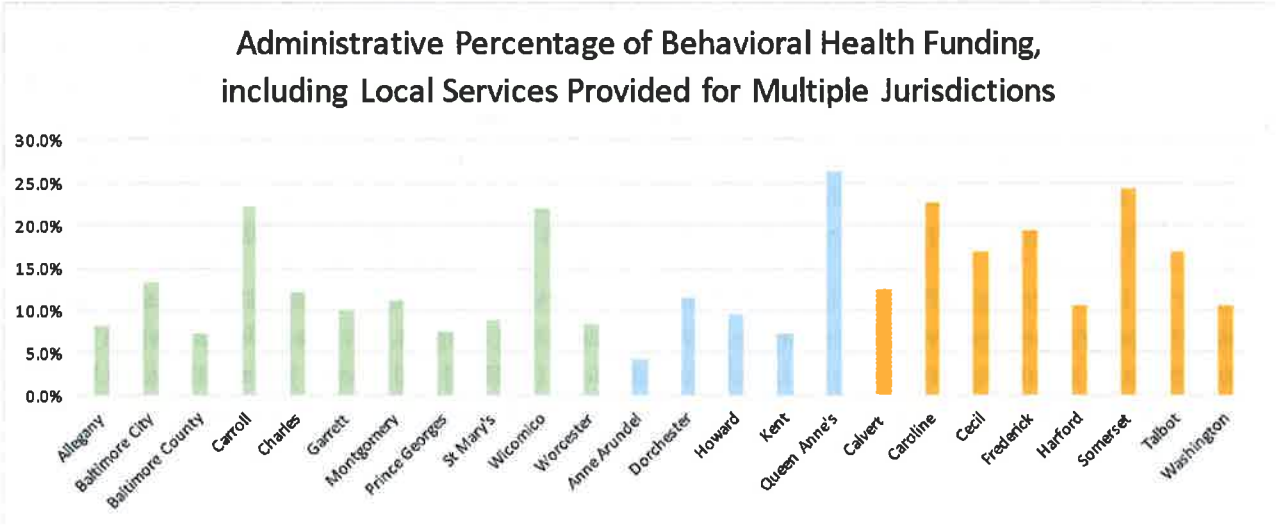



*Figure 7: Estimated Admin % of BH Funding, Color Coded by Integration Level (Green: LBHA; Blue: Mid-Process; Orange: Starting)*

The following charts are more specific, illustrating differences in funding for administrative and treatment costs for CSAs and LAAs, respectively.

Figure 8 below indicates the per person funding levels for administration versus treatment for CSAs, by level of integration. Notably, CSAs within LBHAs (Level 1) appear to spend more per person on treatment and less on administrative activities, as compared to CSAs in local jurisdictions that are just starting to increase alignment and coordination (Level 3).

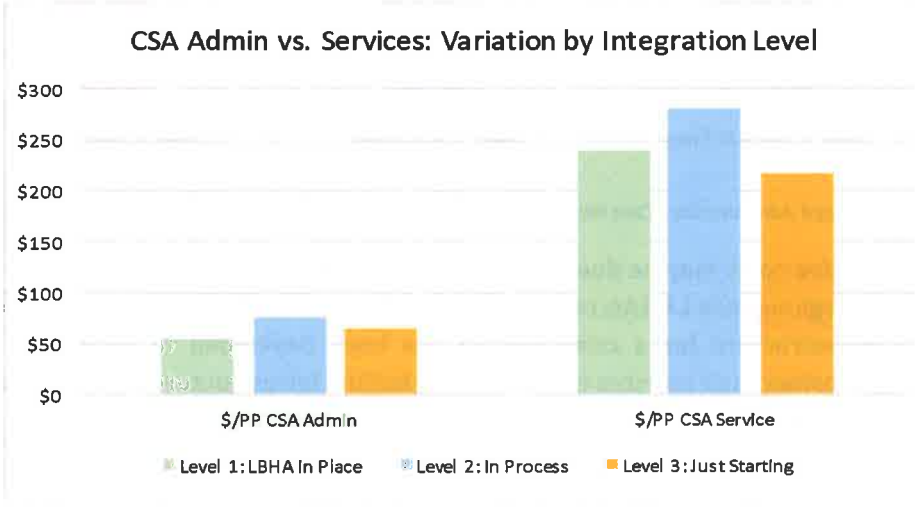



*Figure 8: Estimated Per Person Funding for CSA Administration and Services, grouped by Integration Level*

For LAAs, the experience appears to be similar as shown in Figure 9 below. Per person funding levels for administration versus treatment in LAAs, by level of integration, indicates that LAAs that are part of an LBHA (Level 1) spent more per person on treatment and less per person on administrative activities when compared to LAAs in jurisdictions that are at the beginning stages (Level 3) of increasing local alignment in behavioral health systems management.

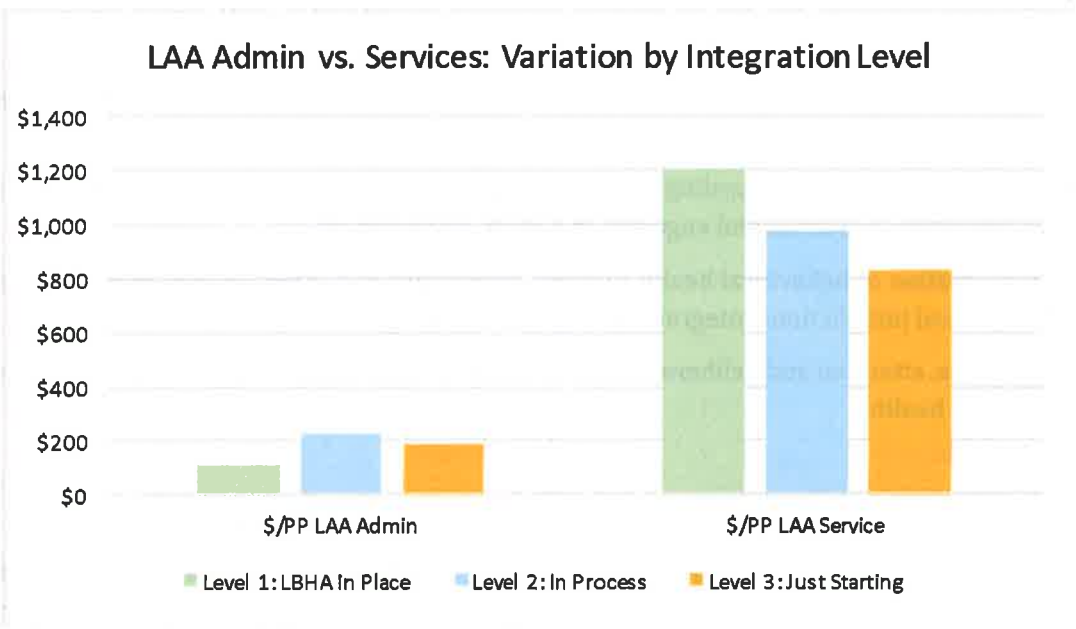



*Figure 9: Estimated Per Person Funding for LAA Administration and Services, grouped by Integration Level*

Estimates of FY2017 expenditures for CSA and LAA services reflected in the charts above do not include funding provided to any local jurisdiction to operate a program that is statewide or serves multiple jurisdictions. In contrast, the administrative expense estimates for FY2017 are likely higher than actual for some jurisdictions, given that the funding associated with administering the statewide or multi-jurisdiction programs may be included in the administrative spending estimates.

For a chart listing the funding for CSA and LAA treatment costs or services in each local jurisdiction, see Attachment E. For a chart listing the funding for CSA and LAA administrative costs in each local jurisdiction, see Attachment F.

## Recommendations and Next Steps

Based on the experiential and financial analyses described above, several considerations drive the recommendations listed below.

- Better coordination and integration of CSA and LAA local systems management is both experientially and financially beneficial, but not all local jurisdictions see a need to fully merge their CSA and LAA organizational structures to accomplish integration.
- Variation in local jurisdictions requires flexibility in approaches, so success may be more likely with a focus on clarifying expected outcomes rather than directing how to achieve those outcomes.
- There are divergent views regarding appropriate and acceptable ways to avoid conflict of interest between providing treatment and engaging in system management.
- Greater integration of behavioral health funding, regulations and other policies will help enable CSAs and LAAs in local jurisdictions integrate their systems management activities.
- It will take time, attention and deliberate support to achieving integration of local systems management for behavioral health.

### 1: Use Guiding Principles to Define and Motivate Greater Integration

Recognizing the 'policy imperative' to integrate behavioral health and the wide variation in structures and circumstances within local jurisdictions, a set of principles are needed to guide the process toward greater integration of systems management at the local level. This affirms the importance of local control and is in contrast to attempting to determine that the same approach for behavioral health system oversight integration should be implemented in every local jurisdiction.

These principles should be jointly developed, with input from all stakeholders, to create a shared vision and build support for the purpose and goals of systems management integration. As part of the information gathering process for this report, discussants and interviewees reviewed and helped refine an initial draft set of principles. All involved expressed support for this approach and the general content developed thus far. See Attachment G for the draft Principles for Integration.

### 2: Increase Clarity from State BHA to Support Local Systems Management

As described in the analysis of experience earlier in this report, the State BHA should work internally and with LBHAs and other CSAs and LAAs to identify, then compile and develop, as needed, a single set of information about policies and processes important for local behavioral health systems management. Communication methods should be reviewed in this process to ensure that CSAs, LAAs and local health officers routinely receive updated information and are able to easily access the full set of policies and related materials as needed.

## 3: Take an integrated approach to behavioral health policy and funding

State policies and funding streams for mental health and substance use oversight and treatment services should be reviewed to identify where they can be aligned or even integrated into a behavioral health approach, if possible. While the state of Maryland cannot change federal laws or programs that are largely separate for mental health and substance use, to the extent that the State can facilitate coordination of financing, reporting, standards and other requirements to support the LBHAs, it should.

This may also include creating financial incentives that reward integration of systems management functions to increase accountability for outcomes and deepen data-driven decision making and the use of evidence-based management practices. This is supported by the financial analysis, as noted above, which indicates that LBHAs, which are more active in system management and oversight for accountability, appear to operate with lower administrative costs while directing a larger portion of their funding into direct treatment and services.

## 4: Develop multi-year plan to support local behavioral health integration

Local jurisdictions want greater clarity about the long term goals for behavioral health system integration, in addition to ideas for how best to approach the local work to integrate behavioral health systems management. Based on the experiences of LBHAs that have been operating for several years, systems management integration is a process that requires deliberate attention over several years. Even the most advanced LBHAs consider themselves a work in progress, and want informational guidance and technical assistance, in addition to opportunities to learn from their peers and the state BHA. Local jurisdictions that are not yet LBHAs also expressed interest in learning from others, with one summing it up by commenting that they would be further along with systems management integration if they knew how to do it.

This recommendation and the specific interests expressed by local jurisdictions will inform the multi-year operational plan to support greater integration in all local jurisdictions that the BHA is in the process of developing. The recommendation is to ensure that this integration plan helps local jurisdictions address technical and operational areas such as: defining and communicating the value-proposition for systems management to providers and community members; stages and key elements of integrated systems management. It should also include effective models, best practices, learning networks, and process improvement. Work that has been underway in some local jurisdictions should inform the integration plan, which should be shaped by local jurisdiction stakeholders from across Maryland.

## Next Steps

This report provides a baseline snapshot of the general status of integration of local behavioral health systems management, as of fall 2017. The BHA intends to use the insights from this report to inform and

refine activities that are already in process or in the planning stages, including convening an operational advisory group consisting of representatives from local mental health (CSAs), substance use (LAAs), and behavioral health (LBHAs) entities, plus patient and provider advocacy organizations, among others. In 2018, this advisory group will work with the BHA to:

a) Help refine and finalize the draft Principles for Integration (see Attachment G); and

b) Develop a multi-year plan for use by local jurisdictions and the BHA to help guide and assist local efforts to integrate systems management within their own regions in ways that are consistent with the Principles for Integration, and that reflect the unique local characteristics and approach to integration as desired and designed by leaders and community members in each local jurisdiction.

The multi-year operational and technical assistance plan will identify the key phases involved in moving along the continuum of integration of local systems management, related milestones, and the topics for which technical assistance or informational resources from the BHA and others may be needed to help local jurisdictions succeed. In addition to providing value to the local jurisdictions, the plan is intended to help guide the BHA's focus in supporting local jurisdictions' efforts to integrate the systems management functions for behavioral health in their own region.

Behavioral health system integration is a complex, multi-year process. As such, there is more work to do within the state BHA and in local jurisdictions to complete the transition to integrated local management and oversight of the behavioral health system.

# Attachments

## Attachment A: List of Stakeholders Interviewed

| Organization | Name |
|---|---|
| Allegany County Behavioral Health Systems | Lesa Diehl, Director |
| Anne Arundel County Mental Health Agency | Adrienne Mickler, Executive Director |
| Baltimore City Health Department | Leana Wen, Health Commissioner |
| Behavioral Health Systems Baltimore | Crista Taylor, President and CEO<br>Adrienne Breidenstine, VP Policy and Communications |
| Community Behavioral Health Association of Maryland | Shannon Hall, Executive Director<br>Lori Doyle, Public Policy Director |
| Maryland Department of Health | Jinlene Chan, Acting Deputy Secretary for Public Health Services |
| MD Behavioral Health Coalition / MD Chapter of National Council on Behavioral Health | Linda Raines, CEO |
| Medicaid | Rebecca Frechard, Chief Policy & Compliance Behavioral Health Division |
| Mid-shore CSA | Holly Ireland, Executive Director |
| Montgomery County Public Health | Uma Ahluwalia, Acting Health Officer |
| Prince Georges County Public Health | Pamela Brown-Creekmur, Health Officer<br>Jacque Duval-Harvey, Deputy Health Officer<br>Christina Waddler, CSA Director |
| Talbot County Health Department | Sarah Cloxton, Director |
| Washington County Mental Health Authority | Rick Rock, Director |
| Wicomico County Health Department | Lori Brewster, Health Officer |

## Attachment B: List of CSAs and LAAs

The assessment of levels of integration was based on current filings of LBHA status with BHA, in addition to the information below, which was compiled in February 2017 by the Maryland Association of Behavioral Health Authorities.

| JURISDICTION | CSA | LAA |
|---|---|---|
| **Allegany County** | **Allegany Co. Mental Health System**<br>P.O. Box 1745,<br>Cumberland, Maryland 21501-1745<br>301-759-5070 Fax: 301-777-5621<br>achd.mhso@maryland.gov<br>**Director: Lesa Diehl** | **Allegany County Health Department**<br>PO Box 1745,<br>Cumberland, Maryland 21501-1745<br>301-759-5050 Fax: 301-777-2098<br>achd.mhso@maryland.gov<br>**Director: Lesa Diehl** |
| **Anne Arundel County** | **Anne Arundel County Mental Health Agency**<br>PO Box 6675, 1 Truman Parkway, 101<br>Annapolis, Maryland 21401<br>410-222-7858 Fax: 410-222-7881<br>mhaaac@aol.com<br>**Director: Adrienne Mickler** | **Anne Arundel County Health Department Behavioral Health,**<br>3 Harry S. Truman Parkway HD24,<br>Annapolis, Maryland 21401<br>410-222-7164 Fax: 410-222-7348<br>Hdonei00@aacounty.org<br>**Director: Sandra O'Neill** |
| **Baltimore City** | **Behavioral Health System Baltimore**<br>One North Charles Street, Suite 1600,<br>Baltimore, Maryland 21201-3718<br>410-637-1900 Fax: 410-637-1911<br>Crista.taylor@bhsbaltimore.org<br>**Director: Crista Taylor**<br>**www.bhsbaltimore.org** | **Behavioral Health System Baltimore**<br>One North Charles Street, Suite 1600,<br>Baltimore, Maryland 21201-3718<br>410-637-1900 Fax: 410-637-1911<br>Crista.taylor@bhsbaltimore.og<br>**Director: Crista Taylor**<br>**www.bhsbaltimore.org** |
| **Baltimore County** | **Baltimore Co. Department of Health, Bureau of Behavioral Health**<br>6401 York Road, Third Floor<br>Baltimore, Maryland 21212<br>410-887-3828 Fax: 410-887-3786<br>kcuthrell@baltimorecountymd.gov<br>**Director: Stephanie House** | **Baltimore Co. Department of Health, Bureau of Behavioral Health**<br>6401 York Road. Third Floor<br>Baltimore, Maryland 21212<br>410-887-3828 Fax: 410-887-3786<br>kcuthrell@baltimorecountymd.gov<br>**Director: Stephanie House** |
| **Calvert County** | **Calvert County Core Service Agency**<br>P.O. Box 980,<br>Prince Frederick, Maryland 20678<br>410-535-5400 Fax: 410-414-8092<br>david.gale@maryland.gov<br>**Director: David Gale** | **Calvert County Health Department**<br>P.O. Box 1180,<br>Prince Frederick, Maryland 20678<br>410-535-3079 x14 Fax: 410-535-2220<br>doris.mcdonald@maryland.gov<br>**Director: Doris McDonald** |

| JURISDICTION | CSA | LAA |
|---|---|---|
| **Caroline County** | **Mid-Shore Behavioral Health, Inc.**<br>28578 Mary's Court, Suite 1<br>Easton, Maryland 21601<br>410-770-4801 Fax: 410-770-4809<br>hireland@midshorebehavioralhealth.org<br>**Director: Holly Ireland** | **Caroline County Addictions Program**<br>403 South 7th Street<br>Denton, Maryland 21629<br>410-479-1882 Fax: 410-479-4918<br>Joe.jones@maryland.gov<br>**Director: Joe Jones** |
| **Carroll County** | **Carroll County Local Behavioral Health Authority**<br>290 South Center Street,<br>Westminster, MD 21157<br>410-876-4800 Fax: 410-876-4832<br>sue.doyle@maryland.gov<br>**Director: Sue Doyle** | **Carroll County Local Behavioral Health Authority**<br>290 South Center Street<br>Westminster, MD 21157<br>410-876-4800 Fax: 410-876-4832<br>sue.doyle@maryland.gov<br>**Director: Sue Doyle** |
| **Cecil County** | **Cecil County Core Service Agency**<br>401 Bow Street<br>Elkton, Maryland 21921<br>410-996-5112 Fax: 410-996-5134<br>shelly.gulledge@maryland.gov<br>**Director: Shelly Gulledge** | **Cecil County Health Department**<br>401 Bow Street<br>Elkton, Maryland 21921<br>410-996-5106 ext. 299 Fax: 410-996-5707<br>ken.collins@maryland.gov<br>**Director: Kenneth Collins** |
| **Charles County** | **Dept. of Health, Core Service Agency**<br>P.O. Box 1050, 4545 Crain Hwy.<br>White Plains, MD 20695<br>301-609-5757 Fax: 301.609-5749<br>DHMH.CharlesCountyCSA@maryland.gov<br>**Director: Karyn Black** | **Charles County Department of Health**<br>P.O. Box 1050 4545 Crain Hwy.<br>White Plains, Maryland 20695<br>301-609-6616 Fax: 301-934-1234<br>sara.haina@maryland.gov<br>**Director: Sara Haina** |
| **Dorchester County** | **Mid-Shore Behavioral Health, Inc.**<br>28578 Mary's Court, Suite 1<br>Easton, Maryland 21601<br>410-770-4801 Fax: 410-770-4809<br>hireland@midshorebehavioralhealth.org<br>**Director: Holly Ireland** | **Dorchester County Addictions Program** 310 Gay Street, Lower Level<br>Cambridge, Maryland 21613<br>410-228-7714 ext. 106 Fax: 410-228-8049<br>donald.hall@maryland.gov<br>**Director: Donald Hall** |

| JURISDICTION | CSA | LAA |
|---|---|---|
| **Frederick County** | **Mental Health Management Agency**<br>22 South Market Street, Suite 8<br>Frederick, Maryland 21701<br>301-682-6017 Fax: 301-682-6019<br>rap@mhma.net<br>**Director: Robert Pitcher** | **Frederick Co HD, Behavioral Health Services**<br>350 Montevue Lane<br>Frederick, Maryland 21702<br>301-600-1755 Fax: 301-600-3214<br>awalker@frederickcountymd.gov<br>**Director: Andrea Walker** |
| **Garrett County** | **Garrett County Core Service Agency**<br>1025 Memorial Drive<br>Oakland, Maryland 21550-1943<br>301-334-7440 Fax: 301-334-7441<br>fred.polce@maryland.gov<br>**Director: Fred Polce** | **Garrett Co. Center for Behavioral Health**<br>1025 Memorial Drive<br>Oakland, Maryland 21550<br>301-334-7670 Fax: 301-334-7671<br>fred.polce@maryland.gov<br>**Director: Fred Polce** |
| **Harford County** | **Office on Mental Health of Harford Co.**<br>125 N. Main Street<br>Bel Air, Maryland 21014<br>410-803-8726 Fax: 410-803-8732<br>jkraus@harfordmentalhealth.org<br>**Director: Jessica Kraus** | **Harford County Health Department**<br>120 Hays Street<br>Bel Air, Maryland 21014<br>410-877-2340 Fax: 410-638-4954<br>paula.nash@maryland.gov<br>**Director: Paula Nash** |
| **Howard County** | **Howard County Mental Health Authority**<br>8930 Stanford Blvd.<br>Columbia, Maryland 21045<br>410-313-7350 Fax: 410-313-7374<br>mmorey@hcmha.org<br>**Director: Madeline Morey** | **Howard County Health Department**<br>8930 Stanford Road<br>Columbia, Maryland 21046<br>410-313-7316 Fax: 410-313-6212<br>rrbonaccorsy@howardcountymd.gov<br>**Director: Roe Rodgers-Bonaccorsy** |
| **Kent County** | **Mid-Shore Behavioral Health, Inc.**<br>28578 Mary's Court, Suite 1<br>Easton, Maryland 21601<br>410-770-4801 Fax: 410-770-4809<br>hireland@midshorebehavioralhealth.org<br>**Director: Holly Ireland** | **Kent County Health Department**<br>300 Scheeler Road, P.O. Box 229<br>Chestertown, Maryland 21620<br>410-778-2616 Fax: 410-778-7052<br>tim.dove@maryland.gov<br>**Director: Tim Dove** |

| JURISDICTION | CSA | LAA |
|---|---|---|
| **Montgomery County** | **Dept. of Health & Human Services** 401 Hungerford Drive, 1st Floor<br>Rockville, MD 20850<br>240-777-1400 Fax: 240-777-1145<br>scott.greene@montgomerycountymd.gov<br>**Behavioral Health Planning and Management: Scott Greene** | **Behavioral Health Manager**<br>401 Hungerford Drive, Suite 458<br>Rockville, Maryland 20850<br>240-777-1671 Fax: 240-777-3307<br>hardy.bennett@montgomerycountymd.gov<br>**Director: Hardy Bennett** |
| **Prince George's County** | **Prince George's Co. Health Dept. Behavioral Health Services Core Service Agency**<br>9314 Piscataway Road<br>Clinton, Maryland 20735<br>301-856-9500 Fax: 301-856-9558<br>lcwaddler@co.pg.md.us<br>**Manager: L. Christina Waddler** | **Prince George's Co. Health Dept. Behavioral Health Services Local Addiction Authority**<br>9314 Piscataway Road<br>Clinton, Maryland 20735<br>301-856-9500 Fax: 301-856-9558<br>lcwaddler@co.pg.md.us<br>**Manager: L. Christina Waddler** |
| **Queen Anne's County** | **Mid-Shore Behavioral Health, Inc.**<br>28578 Mary's Ct, Ste1,<br>Easton, MD 21601<br>410-770-4801 Fax: 410-770-4809<br>hireland@midshorebehavioralhealth.org<br>**Director: Holly Ireland** | **Queen Anne's County Health Department**<br>206 N Commerce St,<br>Centreville, MD 21617<br>410-758-1306 ext 4534 Fax: 410-758-2133<br>gary.fry@maryland.gov<br>**Director: Gary Fry** |
| **Somerset County** | **Wicomico Somerset Behavioral Health Authority**<br>108 E. Main Street<br>Salisbury, MD 21801<br>410-543-6981 Fax: 410-219-2876<br>tammy.griffin@maryland.gov<br>**Director: Tammy Griffin** | **Somerset County Health Department**<br>8928 Sign Post Road<br>Westover, MD 21871<br>443-523-1790 Fax: 410-651-3189<br>Rota.knott@maryland.gov<br>**Director: Rota Knott** |
| **St. Mary's County** | **St. Mary's Dept. of Aging & Human Services**<br>23115 Leonard Hall Drive, P.O. Box 653<br>Leonardtown, Maryland 20650<br>301-475-4200 Fax: 301-475-4000<br>cynthia.brown@stmarysmd.com<br>**Division Manager: Cynthia Brown** | **St. Mary's Dept. of Aging & Human Services**<br>23115 Leonard Hall Drive, P.O. Box 653<br>Leonardtown, Maryland 20650<br>301-475-4200 ext. 1681 Fax: 301-475-4000<br>maryellen.kraese@stmarysmd.com<br>**SA Treatment Coord: Maryellen Kraese** |

| JURISDICTION | CSA | LAA |
|---|---|---|
| **Talbot County** | **Mid-Shore Behavioral Health, Inc.**<br>28578 Mary's Court, Suite 1<br>Easton, MD 21601<br>410-770-4801 Fax: 410-770-4809<br>hireland@midshorebehavioralhealth.org<br>**Director: Holly Ireland** | **Talbot County Health Department**<br>100 S Hanson St,<br>Easton, MD 21601<br>410-819-5600 Fax: 410-819-5691<br>Sarah.cloxton@maryland.gov<br>**Director: Sarah Cloxton** |
| **Washington County** | **Washington Co Mental Health Authority**<br>339 E. Antietam Street, Suite #5<br>Hagerstown, Maryland 21740<br>301-739-2490 Fax: 301-739-2250<br>rickr@wcmha.org<br>**Director: Rick Rock** | **Washington County Health Department**<br>13114 Pennsylvania Avenue<br>Hagerstown, Maryland 21742<br>240-313-3356 Fax: 240-313-3239<br>Victoria.sterling@maryland.gov<br>**Director: Victoria Sterling** |
| **Wicomico County** | **Wicomico Somerset Behavioral Health Authority**<br>108 E Main Street<br>Salisbury, MD 21801<br>410-543-7480 Fax: 410-219-2876<br>tammy.griffin@maryland.gov<br>**Director: Tammy Griffin** | **Wicomico County Health Department**<br>108 E. Main Street<br>Salisbury, MD 21801<br>410-742-3784 Fax: 410-543-6680<br>tammy.griffin@maryland.gov<br>**Director: Tammy Griffin** |
| **Worcester County** | **Worcester County Core Service Agency**<br>6040 Public Landing, P.O. Box 249<br>Snow Hill, Maryland 21863<br>410-632-3366 Fax: 410-632-0065<br>jessica.sexauer@maryland.gov<br>**Director: Jessica Sexauer** | **Worcester County Health Department**<br>6040 Public Landing, P.O. Box 249<br>Snow Hill, MD 21863<br>410-632-3366 Fax: 410-632-0065<br>jessica.sexauer@maryland.gov<br>**Director: Jessica Sexauer** |

## Attachment C: Total Grants to Local Jurisdictions

The chart below lists funding amounts from BHA to local jurisdictions for mental health via CSA and for substance use via LAA. Amounts in the Multi-Jurisdiction column are grants for a local jurisdiction to provide specific behavioral health programs to multiple local jurisdictions or all jurisdictions statewide.

| Behavioral Health Administration<br>Grants to Jurisdictions<br>FY 2017 | | | | |
|---|---|---|---|---|
| | Total Funding | | | |
| Jurisdiction | CSA | LAA | Multi-Jurisdiction | Total |
| Allegany | $1,084,867 | $3,980,471 | $105,080 | $5,170,418 |
| Anne Arundel | $6,332,873 | $6,166,189 | $7,305,882 | $19,804,944 |
| Baltimore City | $14,158,981 | $36,196,499 | $6,482,801 | $56,838,281 |
| Baltimore County | $5,374,735 | $6,335,082 | $0 | $11,709,817 |
| Calvert | $956,155 | $1,529,757 | $119,459 | $2,605,371 |
| Caroline | $440,266 | $1,074,129 | $300,146 | $1,814,541 |
| Carroll | $1,633,349 | $3,366,040 | $0 | $4,999,389 |
| Cecil | $967,521 | $2,035,823 | $0 | $3,003,344 |
| Charles | $1,499,503 | $1,802,553 | $759,150 | $4,061,206 |
| Dorchester | $440,265 | $1,477,654 | $300,146 | $2,218,065 |
| Frederick | $1,760,500 | $2,912,105 | $83,200 | $4,755,805 |
| Garrett | $709,548 | $1,221,988 | $0 | $1,931,536 |
| Harford | $2,755,266 | $1,852,426 | $1,399,875 | $6,007,567 |
| Howard | $2,032,862 | $1,829,587 | $2,697,421 | $6,559,870 |
| Kent | $440,265 | $1,044,518 | $3,717,697 | $5,202,480 |
| Montgomery | $6,051,826 | $5,479,520 | $0 | $11,531,346 |
| Prince Georges | $5,256,445 | $9,499,462 | $0 | $14,755,907 |
| Queen Anne's | $440,265 | $534,060 | $300,146 | $1,274,471 |
| Somerset | $552,354 | $1,314,627 | $187,863 | $2,054,844 |
| St Mary's | $585,623 | $3,714,393 | $0 | $4,300,016 |
| Talbot | $440,261 | $962,249 | $300,145 | $1,702,655 |
| Washington | $1,797,211 | $3,412,386 | $733,807 | $5,943,404 |
| Wicomico | $552,355 | $1,630,485 | $107,979 | $2,290,819 |
| Worcester | $862,551 | $2,814,638 | $663,713 | $4,340,902 |
| | | | | |
| | | | | |
| Total | $57,125,847 | $102,186,641 | $25,564,510 | $184,876,998 |

## Attachment D: Estimated Number of Clients Served by Local Jurisdiction

The chart below lists the estimated number of clients served for mental health via CSAs and for substance use via LAAs. This estimate underrepresents the total number served in each local jurisdiction in FY2017, per the notes at the bottom of the chart.

Behavioral Health Administration
Estimated Number of Clients Served
FY 2017

| COUNTY | Number Served for Mental Health (CSA) | Number Served for Substand Related Disorders (LAA) |
|---|---|---|
| Allegany | 4,722 | 2,778 |
| Anne Arundel | 15,024 | 9,554 |
| Baltimore City | 53,333 | 32,397 |
| Baltimore County | 29,669 | 14,813 |
| Calvert | 2,609 | 1,773 |
| Caroline | 1,856 | 792 |
| Carroll | 4,410 | 2,576 |
| Cecil | 4,876 | 3,901 |
| Charles | 3,675 | 2,260 |
| Dorchester | 2,480 | 1,051 |
| Frederick | 6,616 | 3,139 |
| Garrett | 1,284 | 759 |
| Harford | 7,845 | 4,463 |
| Howard | 5,213 | 1,889 |
| Kent | 899 | 458 |
| Montgomery | 16,908 | 4,413 |
| Prince George's | 19,356 | 4,889 |
| Queen Anne's | 1,428 | 761 |
| Somerset | 1,629 | 763 |
| St. Mary's | 3,113 | 2,212 |
| Talbot | 1,508 | 586 |
| Washington | 8,133 | 4,602 |
| Wicomico | 5,567 | 2,831 |
| Worcester | 2,575 | 1,175 |
| Statewide | 200,421 | 102,634 |

Data Source: MARF0004c./S.MARF0004c
Data based on claims paid through 8/31/2017.
Includes all Coverage Types. Total is Unduplicated.

FY17 data may not be final as a provider has 12 months from time of service in which to submit a claim for payment.

## Attachment E: Funding for Mental Health and Substance Use Treatment Costs

The two charts below detail treatment costs within local jurisdictions. The first chart lists funding from the State Behavioral Health Administration to local jurisdictions for treatment costs for mental health via CSA and for substance use via LAA. Amounts in the Multi-Jurisdiction column are the treatment costs associated with grants for a local jurisdiction to provide specific behavioral health programs to multiple local jurisdictions or all jurisdictions statewide.

| Behavioral Health Administration<br>Grants to Jurisdictions<br>FY 2017 | | | | |
|---|---|---|---|---|
| | Service | | | |
| Jurisdiction | CSA | LAA | Multi-Jurisdiction | Total |
| Allegany | $832,998 | $3,809,540 | $105,080 | $4,747,618 |
| Anne Arundel | $5,847,396 | $5,819,823 | $7,305,882 | $18,973,101 |
| Baltimore City | $11,981,663 | $30,737,674 | $6,482,801 | $49,202,138 |
| Baltimore County | $4,830,322 | $6,015,082 | $0 | $10,845,404 |
| Calvert | $728,935 | $1,431,291 | $119,459 | $2,279,685 |
| Caroline | $314,164 | $788,127 | $300,146 | $1,402,437 |
| Carroll | $1,362,332 | $2,524,952 | $0 | $3,887,284 |
| Cecil | $730,066 | $1,767,050 | $0 | $2,497,116 |
| Charles | $1,229,380 | $1,580,151 | $759,150 | $3,568,681 |
| Dorchester | $314,163 | $1,349,957 | $300,146 | $1,964,266 |
| Frederick | $1,395,998 | $2,352,897 | $83,200 | $3,832,095 |
| Garrett | $557,438 | $1,176,988 | $0 | $1,734,426 |
| Harford | $2,418,696 | $1,548,422 | $1,399,875 | $5,366,993 |
| Howard | $1,692,292 | $1,530,259 | $2,697,421 | $5,919,972 |
| Kent | $314,163 | $794,229 | $3,717,697 | $4,826,089 |
| Montgomery | $5,006,721 | $5,222,320 | $0 | $10,229,041 |
| Prince Georges | $4,466,381 | $9,172,450 | $0 | $13,638,831 |
| Queen Anne's | $314,163 | $323,894 | $300,146 | $938,203 |
| Somerset | $381,862 | $987,335 | $187,863 | $1,557,060 |
| St Mary's | $397,240 | $3,522,956 | $0 | $3,920,196 |
| Talbot | $314,160 | $799,870 | $300,145 | $1,414,175 |
| Washington | $1,473,800 | $3,101,802 | $733,807 | $5,309,409 |
| Wicomico | $381,863 | $1,299,108 | $107,979 | $1,788,950 |
| Worcester | $718,608 | $2,589,714 | $663,713 | $3,972,035 |
| | | | | |
| | | | | |
| Total | $48,004,804 | $90,245,891 | $25,564,510 | $163,815,205 |

This second chart shows funding to local jurisdictions for opioid treatment per the notations at the bottom of the chart.

Behavioral Health Administration
Service Grants to Jurisdictions: Opioid Treatment
FY 2017

| Jurisdiction | CSA | LAA | Opioid* | Total |
|---|---|---|---|---|
| Allegany | $938,078 | $3,630,224 | $179,316 | $4,747,618 |
| Anne Arundel | $13,153,278 | $4,918,927 | $900,896 | $18,973,101 |
| Baltimore City | $15,727,368 | $27,784,858 | $5,689,912 | $49,202,138 |
| Baltimore County | $4,830,322 | $5,343,435 | $671,647 | $10,845,404 |
| Calvert | $848,394 | $1,230,322 | $200,969 | $2,279,685 |
| Caroline | $614,310 | $728,604 | $59,523 | $1,402,437 |
| Carroll | $1,362,332 | $2,035,383 | $489,569 | $3,887,284 |
| Cecil | $730,066 | $1,154,904 | $612,146 | $2,497,116 |
| Charles | $1,988,530 | $1,473,342 | $106,809 | $3,568,681 |
| Dorchester | $614,309 | $1,037,587 | $312,370 | $1,964,266 |
| Frederick | $1,479,198 | $2,080,452 | $272,445 | $3,832,095 |
| Garrett | $557,438 | $1,067,253 | $109,735 | $1,734,426 |
| Harford | $3,818,571 | $1,265,443 | $282,979 | $5,366,993 |
| Howard | $4,389,713 | $1,320,205 | $210,054 | $5,919,972 |
| Kent | $864,309 | $3,902,642 | $59,138 | $4,826,089 |
| Montgomery | $5,006,721 | $4,984,532 | $237,788 | $10,229,041 |
| Prince Georges | $4,466,381 | $8,789,101 | $383,349 | $13,638,831 |
| Queen Anne's | $614,309 | $306,459 | $17,435 | $938,203 |
| Somerset | $489,842 | $941,821 | $125,397 | $1,557,060 |
| St Mary's | $397,240 | $3,323,445 | $199,511 | $3,920,196 |
| Talbot | $614,305 | $746,113 | $53,757 | $1,414,175 |
| Washington | $2,132,755 | $2,924,546 | $252,108 | $5,309,409 |
| Wicomico | $489,842 | $1,021,972 | $277,136 | $1,788,950 |
| Worcester | $814,324 | $2,913,391 | $244,320 | $3,972,035 |
| Total | $66,941,935 | $84,924,961 | $11,948,309 | $163,815,205 |

* Only Specifically Identified Opioid Programs
There are other programs that treat Opoid, however, they are combined within Treatment Services

## Attachment F: Funding for Mental Health and Substance Use Administrative Costs

The chart below lists funding amounts from the State Behavioral Health Administration to local jurisdictions for administrative costs for mental health via CSA and for substance use via LAA.

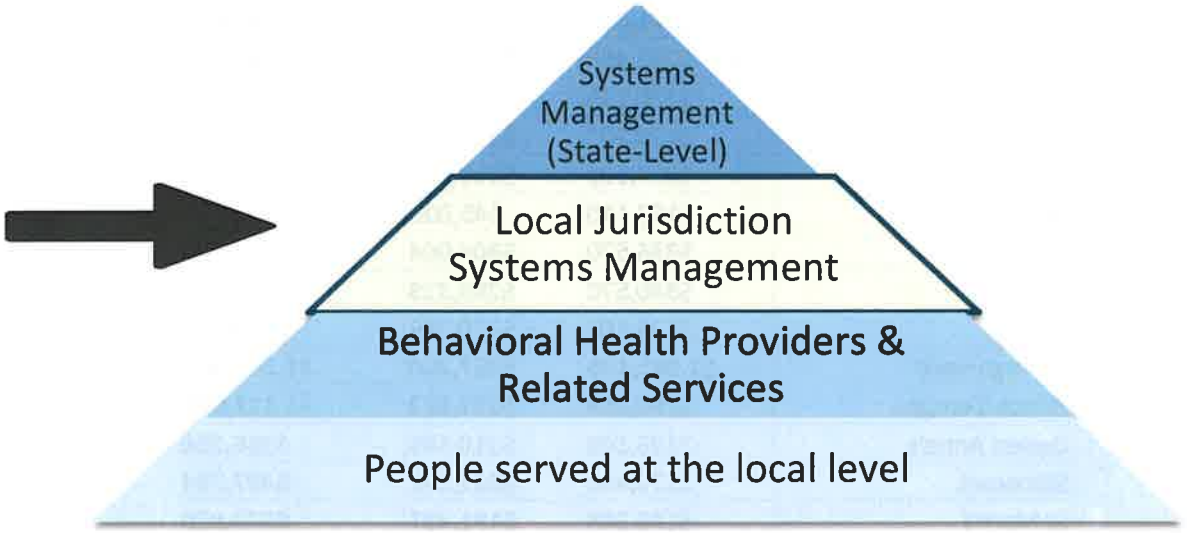
| Behavioral Health Administration<br>Grants to Jurisdictions<br>FY 2017 | | | |
|---|---|---|---|
| | Administrative | | |
| Jurisdiction | CSA | LAA | Total |
| Allegany | $251,869 | $170,931 | $422,800 |
| Anne Arundel | $485,477 | $346,366 | $831,843 |
| Baltimore City | $2,177,318 | $5,458,825 | $7,636,143 |
| Baltimore County | $544,413 | $320,000 | $864,413 |
| Calvert | $227,220 | $98,466 | $325,686 |
| Caroline | $126,102 | $286,002 | $412,104 |
| Carroll | $271,017 | $841,088 | $1,112,105 |
| Cecil | $237,455 | $268,773 | $506,228 |
| Charles | $270,123 | $222,402 | $492,525 |
| Dorchester | $126,102 | $127,697 | $253,799 |
| Frederick | $364,502 | $559,208 | $923,710 |
| Garrett | $152,110 | $45,000 | $197,110 |
| Harford | $336,570 | $304,004 | $640,574 |
| Howard | $340,570 | $299,328 | $639,898 |
| Kent | $126,102 | $250,289 | $376,391 |
| Montgomery | $1,045,105 | $257,200 | $1,302,305 |
| Prince Georges | $790,064 | $327,012 | $1,117,076 |
| Queen Anne's | $126,102 | $210,166 | $336,268 |
| Somerset | $170,492 | $327,292 | $497,784 |
| St Mary's | $188,383 | $191,437 | $379,820 |
| Talbot | $126,101 | $162,379 | $288,480 |
| Washington | $323,411 | $310,584 | $633,995 |
| Wicomico | $170,492 | $331,377 | $501,869 |
| Worcester | $143,943 | $224,924 | $368,867 |
| | | | |
| Total | $9,121,043 | $11,940,750 | $21,061,793 |

## Attachment G: Draft Principles for Integration

*Maryland Behavioral Health Integration Project*
**PRINCIPLES FOR LOCAL SYSTEMS MANAGEMENT INTEGRATION**
**September 2017 DRAFT**

### DEFINTION OF INTEGRATION REGARDING LOCAL JURISDICTIONS

Integration is the strategic alignment and coordination of *systems management resources at the local jurisdiction level*, to ensure quality of services and support for individuals with behavioral health conditions and increase the effectiveness and efficiency of behavioral health system, without compromising the integrity of local programs' missions or objectives.[10] This is not 'one size fits all', as there are many ways to envision, structure, approach and achieve integration.




### FOCUS ON LOCAL JURISDICTION SYSTEMS MANAGEMENT

Systems management, including planning and accountability for the overall quality and patient outcomes from the local behavioral health system, is an important role within each local jurisdiction. It is distinct from directly providing services or operating treatment programs which are billed to the ASO. The role of system management and planning involves serving in a neutral capacity to oversee the entire behavioral health system in the local jurisdiction.

[10] Largely based on a definition of integration presented in Salinsky E, Gursky EA. The case for transforming governmental public health. Health Aff (Millwood) 2006;25(4):1017-28.

## PRINCIPLES FOR INTEGRATION

Behavioral health agencies with integrated systems management at the local level operate in accordance with each of the 12 principles below, through structures and relationships most appropriate for their local region.

### Meeting Individuals' Needs as the Top Priority

1. **Create a system of care that ensures a "no wrong door" experience** so that when a person contacts any of the organizations involved in the local behavioral health system, they are seamlessly connected with what they need regarding unhindered access to mental health and/or substance use services and supports, regardless of age, income, disability, housing status or other factor. Ideally, this includes access to non-medical resources as needed to achieve optimal results, such as peer support, wellness and recovery centers and housing.

2. **Meet the needs of individuals** at risk of or with serious behavioral health issues, along with their loved ones, by addressing the individual's physical, mental, substance use and wellness goals – with cultural and linguistic humility – in the least restrictive, most normative, and most appropriate setting.

3. **Make understandable and relevant information readily available** for individuals to enter and proceed through the behavioral health system in an appropriate and timely manner.

### Collaboration between Service Providers and System Partners

4. **Facilitate collaboration among providers within the behavioral health network and between providers and other public and private human or health service systems** (*e.g.*, hospitals, long term care facilities, primary and specialty medical groups, justice and child welfare systems) to promote the development of person-centered plans that ensure continuity of care and facilitate support with all activities of life, including but not limited to housing, transportation, food support, education, child welfare, and legal needs.

5. **Establish relationships and partnerships to ensure clear channels of communication** among providers and system partners to share information, identify gaps within the system of care, develop methods to meet identified gaps, and implement new and innovative service delivery within the system of care.

**Accountable Management**

6. **Ensure provider network adequacy,** including advocating for necessary funding for behavioral health providers, meeting with new behavioral health providers in the local jurisdiction, investigating complaints, promoting quality service delivery, and supporting provider efforts to achieve accreditation and become effective members of the local system of care.

7. **Provide a single point of contact** for all behavioral health financial arrangements and performance agreements with the state Behavioral Health Administration, including accountability for outcomes of the funded and planned programs and activities.

8. **Engage in data-driven decision-making**, including but not limited to forecasting the need for behavioral health services within the local region, ensuring adequate capacity to meet that need, evaluating effectiveness of existing services, and providing evidence that supports the need for new or refined approaches.

9. **Operate using efficient and effective business practices and processes**, in addition to recruiting, training, and retaining competent and committed staff who are given opportunities to enhance their professional skills.

10. **Use and promote the use of evidence-based practices and monitor program activities and practice implementation,** engaging in evaluation to inform rapid response to identified gaps in the system, adaptation to changing needs, and improved use of technology.

11. **Apply outcome measures**, some of which will be jointly identified with the BHA, as a key component for evaluating program and provider effectiveness, including but not limited to measuring the perception of care and satisfaction with the services received, from the individuals' perspective, and involving loved ones as appropriate.

12. **Ensure efficient use of public resources** including maximizing Medicaid and other insurance reimbursement in combination with grant funds, when possible, for systems management and service implementation consistent with all of the principles listed above.

*NOTE: This draft of the Principles for Integration of behavioral health systems management within local jurisdictions reflects initial input from a range of local and state stakeholders. In the coming months, the principles will be refined, finalized and incorporated into a statewide plan being developed by the Behavioral Health Administration to support local jurisdictions' continued progress in integrating systems management.*