MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH's New Behavioral Health Integration Model

November 21, 2013

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Agenda

- Background and Goals
- Integrated Behavioral Health Eligibility Policy for the Uninsured
- Proposal to Authorize and Pay for Substance Use Disorder Services
- Role of the Local Authorities
- Expanding Current Outcome Measures
- Fiscal Impact of the Model and Changes to Rate-Setting

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BACKGROUND AND GOALS

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Background

- FY 2012: The Department charged* with developing "a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues"
- Three-phase process to develop integrated health service delivery and financing system
- Supported by inputs from consumers, providers and advocates

* *Maryland General Assembly*

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Phase I (2011): Assessment

- Participants: the Department, a consultant and stakeholders
- Strengths: Greatly improved access to care in recent years in each separate domain
- Weaknesses
  - Poor alignment of benefit design and management
  - Fragmented purchasing and financing
  - Siloed care management
  - Inadequate performance and risk measures
  - Need for integrated care

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Phase II (2012-13): Model Development

- Series of large public stakeholder meetings with public comment period
- Cross-disciplinary leadership steering committee recommended performance-based carve-out model integrating mental health and substance use services under a single administrative services organization
- Advantages:
  - Streamlines duplicative financing systems
  - Integrates care by aligning incentives and performance targets
  - Establishes a single Behavioral Health Administration (BHA)
  - Expands interfaces with related State systems

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Phase III (2013): RFP Development and Other BHI Issues

Additional stakeholder meetings held to further inform the model:

- Financial incentives
- Shared savings
- Care coordination
- Prior authorization
- Quality reports and measures (performance incentives and sanctions)
- Billing issues
- Managed care organization (MCO) specifications
- Data sharing
- Beneficiary protections
- Communication and collaboration

The Department plans to release the RFP in early 2014.

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Goal of the Behavioral Health Model

Provide a seamless service delivery system that protects consumers and the public while providing timely access to services, care coordination and wellness and recovery for all individuals, both covered by Medicaid and the uninsured

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Achieving Integrated Behavioral Health

- **Align financial incentives:** Performance-based incentives and penalties will be built into the administrative services organization (ASO) contract; future years may extend incentives—and shared savings—to providers
- **Resolve adverse selection:** Ensure patients receive services in the most appropriate setting, rather than based on perceived benefits to providers; prevent cost-shifting by the ASO or MCOs

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Achieving Integrated Behavioral Health

- **Promote information exchange:** Streamline mental health and substance use information collection into one system via the ASO, promoting information exchange and collaboration
- **Establish multidisciplinary care coordination teams:** ASO staff with mental health and substance use disorder (SUD) experience; coordination with Core Service Agencies (CSAs), Local Addictions Authorities (LAAs) and MCOs
- **Develop competent provider networks:** Evidence-based training for providers; requirements for licensing or accreditation—improving network provider competency

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ELIGIBILITY POLICY FOR THE UNINSURED

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Current Eligibility for the Uninsured

- Access to treatment services provided to:
  - Individuals who do not have access to other insurance
  - Have incomes generally below 200% of the FPL
  - Exception: Medicaid enrollees have access to non-Medicaid covered services
- Key Difference between the Alcohol and Drug Abuse Administration (ADAA) and the Mental Health Administration (MHA)
  - ADAA applies a sliding fee schedule (above 200% FPL) and MHA does not

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Eligibility under the New BHI Model

- Through behavioral health integration, the Department is proposing one standard behavioral health policy for those accessing state-only services.
- There will be no sliding fee schedule for individuals in the Public Behavioral Health System (PBHS).

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Proposed Standard Policy

- Individuals without insurance will be able to access federal grant and state-only funds for services
- Medicaid enrollees will continue to have access to non-Medicaid covered services
- BHA will provide eligibility for services up to three months based on medical necessity to individuals who meet the following criteria *(continued on next slide)*

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Proposed Standard Policy

- Requires treatment for a behavioral health diagnosis covered by the PBHS;
- Is under 250 percent of the FPL, and not covered by Medicaid or other insurance;
- Has a verifiable Social Security Number;
- Is a Maryland resident; and
- Has applied to:
  - Medicaid;
  - The Exchange;
  - Supplemental Security Insurance (SSI); or
  - Social Security Disability Insurance (SSDI) if they have an illness/disability for a period of 12 months or more (or are expected to have an illness/disability for a period of 12 months or more).

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Temporary Exceptions*

- Currently receives SSDI for mental health reasons;
- Is under 18;
- Is homeless within the state of Maryland;
- Was released from prison, jail, or a Department of Correction facility within the last three months;
- Is pregnant;
- Is an intravenous drug user;
- Has HIV/AIDS;
- Was discharged from a Maryland-based psychiatric hospital within the last three months;
- Was discharged from a Maryland-based Medically-Monitored Residential Treatment Facility (American Society of Addiction Medicine (ASAM) Level III.7) within the last 30 days;
- Is requesting services as required by a HG 8-507 order or referred by drug or probate court; or
- Is receiving services as required by an order of a Conditional Release.

** Consumers who are not U.S. citizens but meet one of the temporary exceptions above would be eligible for temporary services.*

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In summary…

Current System

- Services provided to individuals generally under 200% FPL
- ADAA applies a sliding fee schedule above 200%
- Services authorized by…
  - Mental Health: Current ASO with MHA and CSAs
  - SUD: MCOs and local authorities, depending on funding source and level of service

Proposed System

- Services provided to individuals under 250% FPL
- There will be no sliding fee for either mental health or SUD services
- A single ASO will authorize all mental health and outpatient SUD services (assessments, counseling, opioid maintenance and intensive outpatient services)

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AUTHORIZATION AND PAYMENT FOR SUBSTANCE USE SERVICES

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Overview of Authorization, Payment and Data Collection for SUD Services

Service Type	Eligibility	Authorization	Payment	Data collection
Medicaid-reimbursable service	Medicaid-insured	ASO	ASO	ASO
Medicaid-reimbursable service	Uninsured	ASO	ASO	ASO
Non-Medicaid reimbursable service (e.g., residential services)	Either	Local Authority	Local Authority	ASO

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ROLE OF THE LOCAL AUTHORITIES

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Integrating the Local Authorities

- **Core Service Agencies:** Planning and management—administrative and contractual functions—of the local *mental health system*
- **Local Addictions Agencies:** Planning, development and management—including contractual functions—of a local continuum of care for *substance use services*
- **Common function:** Provision of clinical information and service referrals to consumers and family members, both Medicaid and non-Medicaid
- **Moving forward:** Monitor programs and access to services within their jurisdictions, assist with transitions of care and collaborate with the Department to oversee clinical standards

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Integrating the Local Authorities

- CSAs and LAAs are at various stages of integration
- This is a natural progression, as both maintain strong ties with the same community providers and partners
- The integration process should be allowed to progress organically and be sensitive to local strengths and needs

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EXPANDING CURRENT OUTCOME MEASURES

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Both MHA and ADAA collect and measure outcome-level indicators

- Enhanced data sharing across the system will improve coordination and outcomes
- More robust and integrated data reporting under the new model will allow the Department to measure additional outcomes

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Examples of Additional Outcomes

- Reducing the total cost of care from mental health and addictions services, and also from somatic services, per member per month
- Increasing the number of providers in the PBHS cross-trained in both mental health and SUD treatment
- Increasing the number of patients completing SUD treatment through enhanced data sharing and tracking of patients in care
- Increasing the number of individuals trained in suicide awareness and prevention

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FISCAL IMPACT OF THE MODEL AND CHANGES TO RATE-SETTING

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Key Areas of Responsibility for ASO

Medicaid Covered Benefits

- Continue to administer Medicaid specialty mental health services
- Administer Medicaid substance use services

Uninsured and Non-Medicaid Covered Benefits

- Continue to administer mental health services to the uninsured and benefits not covered under the Medicaid program
- Administer outpatient substance use services to the uninsured population ("services that would be covered by Medicaid if a person were enrolled in Medicaid")

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Estimating ASO Cost Using Current ASO (~1.5% of the cost of the service benefit)

Specialty Mental Health Populations	$ Millions		
Populations	FY 2011	FY 2012	FY 2013*
Uninsured	$19.8	$18.6	$16.4
Medicaid—State-Only Covered Services	$44.1	$48.1	$48.5
Medicaid—Covered Services with Federal Match	$591.3	$606.5	$602.3
Total	$655.2	$673.2	$667.2
Cost of ASO Contract	$9.97	$10.27	$10.57
Percentage of Service Cost	**1.5%**	**1.5%**	**1.6%**

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FY 2013 is not complete—providers have 12 months to bill.

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Other Potential Drivers of Cost

- Medicaid Expansion under Affordable Care Act
  - Impact not unique to behavioral health integration
  - Behavioral health needs of the population already largely known from the Primary Adult Care program
- Uninsured / Non-Medicaid Programs and Services
  - Continued need for services not covered by Medicaid or Qualified Health Plans

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Defining Substance Use Carve Out

- The Department is finalizing the substance use procedure codes and diagnoses that will be covered under the ASO
- For inpatient and outpatient hospital services, our goal is to focus on certain revenue codes where the primary diagnosis is substance use related
- MCO will still be responsible for medical issues resulting from long-term substance use disorders, e.g., cirrhosis of the liver

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Estimated SUD Medicaid Expenditures – FY 2015*

Program	Total
HealthChoice Carve-Out (Includes PAC enrollees with full benefits and projected new enrollees)	$237 million
Fee-for-service	$13 million
Total	**$250 million**
ASO Cost (~1.5% of total)	**$3.75 million**

**Based on draft policy of SUD carve-out definitions and includes hospital inpatient services.*

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Estimated ASO Cost for Outpatient Services for the Uninsured

- In FY 2014, grant services provided roughly $27.8 million to local jurisdictions for outpatient services
- Assuming the cost to manage these services is approximately 1.5% of medical services, the ASO cost would be $420,000

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MCO Rates Will Be Adjusted

- Downward adjustment will be applied to the rates paid to the MCOs
- Adjustment will be determined by actuaries
- Calculations will take place during the 2015 rate-setting process, which begins February 2014

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Lost Rate Stabilization Funds

- Fund collects monies from a two percent tax on MCO revenue
- This tax is not applicable to ASO arrangements
- A carve-out of SUD services therefore lowers the tax revenue collected by the State related to the premium tax on MCO revenue
- However, the actual tax loss to the Department is only one percent, as the State pays for only part of the tax in the MCO capitation rates

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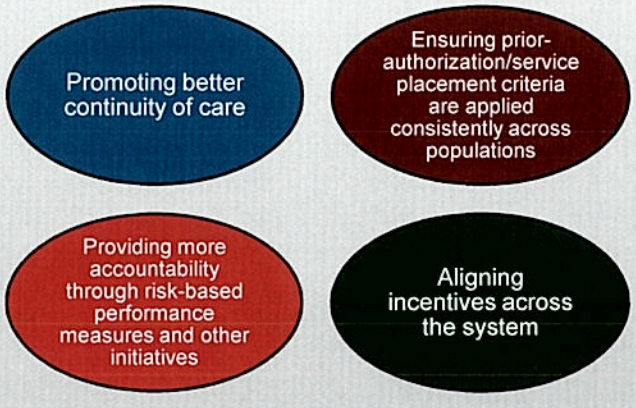
Improving quality and bend the cost curve



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Proposed Allocation of Risk-based Performance Measures

- Up to 10% of the ASO contract will include risk-based performance measures allocated across:
  - Nationally-recognized consumer outcome measures (e.g., HEDIS);
  - State-specific consumer outcome measures;
  - Customer service metrics; and
  - Provider service measures.

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Summary of New ASO Costs

New Costs / Lost Revenue / Offsets	Estimated Annual Total Fund Amount	Estimated Annual General Fund
1. Adding Medicaid Covered Substance Use Services Under ASO Contract	$3.75 million	$1.875 million
2. Adding Certain Substance Use Services Provided to Uninsured Under ASO Contract	$420,000	$420,000 (ineligible for federal match)
3. Lost Revenue from Rate Stabilization Fund	$2.37 million federal	$2.37 million federal
Offsets	**Estimated Amount**	
1. Adjusting MCO rates	Estimated to equal the SUD portion of the ASO contract or $3.75 million.	Estimated to equal the SUD portion of the ASO contract or $1.875 million.
Total New Costs/Lost Revenue (after MCO adjustment): $2.79 million (GF) *Note: This cost/lost revenue would only be for six months in FY 2015, since new ASO will start in Jan. 2015.*		
Improving Quality of Care and Bending the Cost Curve	One percent reduction in inpatient services will save the Department $1.62 million	

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Next Steps

- Finalize JCR: the Department is receiving comments through COB Tuesday, November 26, 2013. Comments should be sent to Alyssa.Brown@Maryland.gov
- Release RFP in early 2014 with the goal of implementing a new system in January 2015
- Continue to work collaboratively with stakeholders

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