COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

December 2, 2024

hscrc.payment@maryland.gov

RE: Comments on 2025 Funding for AHEAD Preparation

To Whom It May Concern:

On behalf of the Community Behavioral Health Association of Maryland (CBH), thank you for the opportunity to provide comments on the Maryland Health Services Cost Review Commission (HSCRC) "2025 Funding for AHEAD Preparation" draft recommendations. CBH is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

We are grateful to HSCRC for developing these recommendations to reinvest the one-time TCOC Model savings. CBH strongly endorses the creation of the fund to support successful implementation of the AHEAD model. Below, we offer several considerations for the HSCRC for modification of the fund's seven target areas, as well as several specific suggestions for future fund expenditures.

Recommendation: Funds should be administered through a governance process that incorporates conflict-free decision-making, transparency, and open dialogue.

CBH recommends that the funds be administered independently from Maryland hospitals and by relying on a sound process reflecting best practices for governance. Hallmarks of good governance should include:

- Conflict-free decision-making to ensure that entities who benefit from funds do not make decisions about where to allocate funds;
- Commitment to dialogue, with no participating providers subject to non-disclosure agreements or other contractual limits on their ability to inform policy and operational discussions;
- Notice and an opportunity to comment by the public and stakeholders on material policy decisions made by the fund administrators; and
- Public availability of information about the amounts and entities to whom funds have been awarded and the result(s) achieved.

Recommendation: Investments in "common platforms and efforts" should be expanded from hospital system to include community-based behavioral health organizations.

The HSCRC's draft recommendations include using funds on "[c]ommon platforms and efforts for the hospital system to improve efficiency and effectiveness of care." CBH encourages the HSCRC to broaden this recommendation to include investments among community-based mental health and addiction treatment providers.

As the Maryland Health Care Commission (MHCC) has noted, "Challenges in securing affordable community-based care may contribute to increases in the average length of stay of acute psychiatric patients over time."[1] Through its aligned provider network, Maryland Behavioral Health Solutions (MBHS), CBH has supported its member work to connect to CRISP, reduce hospital admissions and improve timely follow-up care. CBH members who participate in the MBHS provider network – enabled with analytics to strengthen their performance on HEDIS follow-up measures – demonstrate even stronger performance in 7-day follow-up than Maryland's public behavioral health system as a whole or the average NCQA Medicaid HMO:

Follow-Up After ED Visit for Mental Illness (2022)	Within 7 days
NCQA Medicaid HMO	42%
Maryland PBHS	N/A
MBHS Provider Network	53%

Follow-Up After Hospitalization for Mental Illness (2022)	Within 7 days
NCQA Medicaid HMO	37%
Maryland PBHS Performance	49%
MBHS Provider Network	52%

Strengthening the use of CRISP across community-based behavioral health programs through a coordinated effort, like that led by MBHS, can help ensure success in the AHEAD model's behavioral health goals. For these reasons, we encourage the HSCRC to consider broadening technology investments beyond hospital systems, as well as consider targeted investments like strengthening the MBHS data warehouse work across multi-provider systems.

Recommendation: Access expansions to meet latent demand for high-value clinical services should explicitly target expansion of critical behavioral health infrastructure.

It is widely recognized that community-based mental health and addiction treatment programs are radically under-resourced. CMS has recognized that Medicare rate-setting systemically undervalues behavioral health,[2] and the MHCC has issued a series of reports in recent years itemizing the need to strengthen Maryland's community-based behavioral health services. In 2021, the MHCC noted:

[1] Maryland Health Care Commission, "State Health Plan for Facilities & Services: Acute Psychiatric Services," at p. 5 (Aug. 9, 2021).
[2] Federal Register, Vol. 88, No. 150, p. 52320 ("We continue to believe that there is a systemic undervaluation of work estimates for behavioral health services.") (Aug. 7, 2023).

> The lack of community resources and discontinuity of care leaves many individuals with mental disorders vulnerable to poor outcomes and shifts an immense burden of care to families. If funding for community health resources were increased, it should be possible to achieve more timely discharge and more efficient use of acute psychiatric beds. The General Assembly, the Governor, the Department of Health, and local government agencies should support greater investment in community-based mental health services.[3]

Similarly, in 2024, the Maryland General Assembly Hospital Throughput Work Group echoed the call for investment in sustainable funding for behavioral health programs.[4] Meanwhile, the MHCC's behavioral health workforce identified that Maryland had half the needed workforce and the existing workforce is not competitively compensated compared to surrounding jurisdictions.[5]

Given the well-documented need to strengthen Maryland's community behavioral health capacity, CBH suggests that the recommendation specifically identify this area as an intended target for the fund.

CBH further invites the HSCRC and stakeholders to prioritize capacity-building for statewide deployment of the Certified Community Behavioral Health Clinic (CCBHC) model to align with the goals of the AHEAD model. Under SB363, the Maryland Department of Health is required to apply for a Medicaid demonstration program launching by July 1, 2026, to sustain and expand Maryland's CCBHCs. The CCBHC model has demonstrated success in partnering with hospitals to better serve those with behavioral health needs, while strengthening access to hard-to-serve populations.[6]

Recommendation: Additional pay-for-performance programs should explicitly target community behavioral health initiatives.

In 2023, the Maryland General Assembly passed three bills requiring Medicaid to adopt value-based purchasing pilot programs in community behavioral health services, including a pilot program to reduce hospital utilization (SB 581**,** SB 582 / HB 1148), as well as at least one value-based purchasing contract for youth-oriented targeted case management services (SB 255 / HB 322). Unfortunately, Medicaid funding for behavioral health VBP pilot was zeroed out earlier this year.

Given the challenges facing Maryland's behavioral health services and the importance of behavioral health to the success of the AHEAD model, CBH encourages the HSCRC and fund administrators to consider pay-for-performance programs that encourage alignment of effort between hospitals and community behavioral health programs. To that end, we have appended a VBP proposal that our provider network, Maryland Behavioral Health Solutions previously offered to MDH for

[3] Maryland Health Care Commission, "State Health Plan for Facilities & Services: Acute Psychiatric Services," at p. 6 (Aug. 9, 2021).
[4] Final Report, p. 2 (March 2024).
[5] Maryland Health Care Commission, "Investing in Maryland's Behavioral Health Talent," pp. 4, 59 (October 2024).
[6] National Council for Mental Wellbeing, "2024 CCBHC Impact Report," at pp. 12-15, 35-36.

consideration. This proposal is included with this letter below in Appendix A. We believe that a VBP approach to behavioral health services is a critical component for future success in the AHEAD model.

Thank you again for the opportunity to share feedback on the draft recommendations for 2025 funding for AHEAD preparation. We welcome any questions or further discussion about CBH's feedback described here. Please do not hesitate to contact me at shannon@mdcbh.org. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director

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APPENDIX A: IMPROVING MARYLAND EMERGENCY DEPARTMENT CAPACITY BY ADDRESSING BEHAVIORAL HEALTH DIVERSION OPPORTUNITIES

PROPOSAL FOR VALUE-BASED PURCHASING PILOT

In 2023, three bills requiring Medicaid to adopt value-based purchasing pilot programs passed both chambers of the Maryland General Assembly and were signed by Governor Moore. The Behavioral Health Care Coordination Value-Based Purchasing Pilot Program (SB 581**)** creates a 3-year pilot program beginning with a budget appropriation in FY2025. The pilot must involve at least 500 adults who are at high risk of emergency department or inpatient utilization due to behavioral health issues. It requires a per member per month (PMPM) care management fee and establishes outcome measures that are tied to provider payment. The same requirements for a pilot program are echoed in Behavioral Health Care – Treatment and Access – Behavioral Health Model for Maryland (SB 582 / HB 1148), Senator Ferguson's omnibus bill. Finally, SB 255 / HB 322 (Public Health—Home and Community-Based Services for Children and Youth) requires MDH to fund at least one value-based purchasing contract for targeted case management services.

Maryland Behavioral Health Solutions (MBHS) is a provider network composed of 29 participating mental health and addiction treatment organizations located throughout the state. MBHS and its participating providers have the experience and shared data infrastructure to launch and effectively deliver a value-based purchasing pilots as contemplated in the legislative initiatives passed by the Maryland General Assembly.

A. ELIGIBLE PROVIDERS: AUTOMATED DATA EXCHANGE WITH CRISP

Legislation describing the value-based purchasing (VBP) pilot program requires participating providers to "have an automated data exchange with the state-designated health information exchange" (Md Code Health – General at § 13-4804(D)(4).

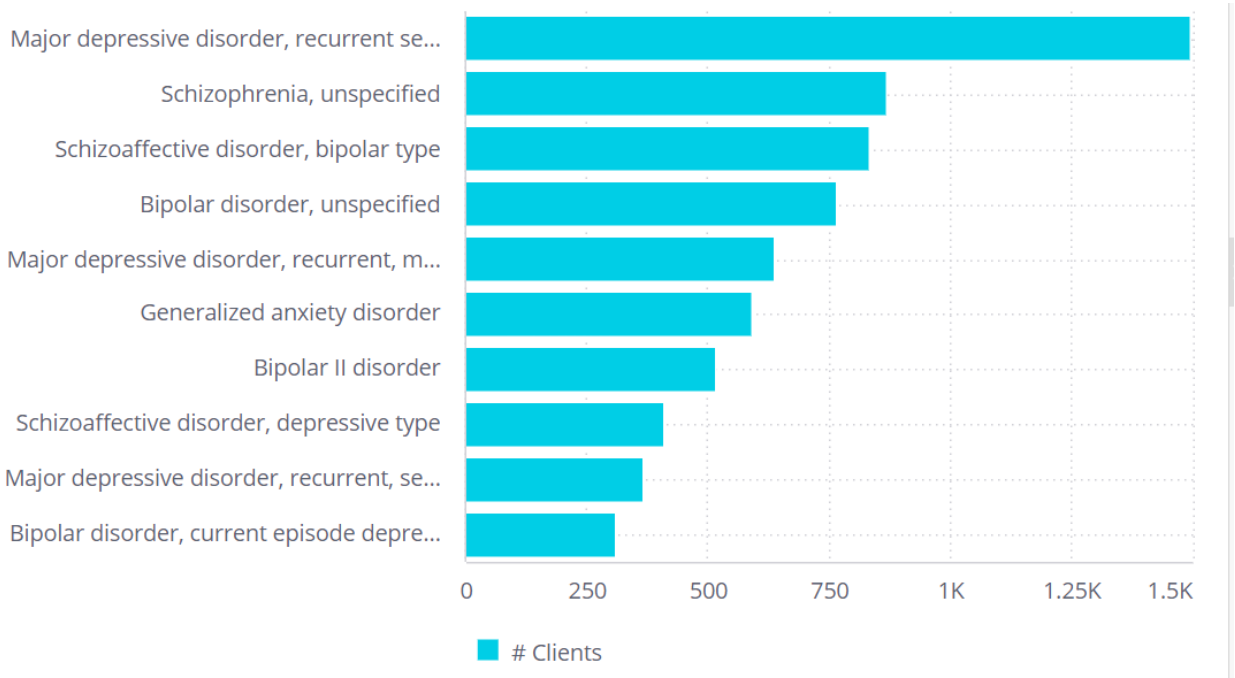
The Maryland Behavioral Health Solutions (MBHS) provider network has facilitated automated data exchange with CRISP for seven of its participating providers, and all 29 providers participating in the network are eligible to join the automated data exchange. Using the network's data warehouse as an intermediary, active patient panels and CRISP data are exchanged daily between participating providers and the state HIE. Data is delivered to providers in actionable analytics dashboards.

Currently, MBHS participating providers with automated data exchange are located in more than half of Maryland jurisdictions, including some with long ED wait times in the state:

- Arundel Lodge in Anne Arundel County
- Channel Marker in Caroline, Talbot and Dorchester Counties
- Cornerstone in Montgomery and Calvert Counties
- Lower Shore Clinic in Wicomico, Worcester and Somerset Counties
- Partnership Development Group in Baltimore City, Anne Arundel and Montgomery Counties
- Pathways in St. Mary's County

B. Eligible Patients: Active with Eligible Provider + Inpatient or ED Discharge

In CY2023, the seven organizations with automated data exchange served 10,990 clients, including 1,040 children under the age of 18. Over two-thirds of individuals served had diagnoses related to schizophrenia, major depression, or bipolar disorder.



In CY2023 there were 3,989 unique patients active with participating providers who had an ED visit or inpatient discharge. These 3,989 patients accounted for 12,125 total hospital discharges in the preceding year, of which 79% were ED visits.

MBHS proposes that the eligible patient population be identified for purposes of the VBP pilot as any patient active with one of the eligible providers at time of an inpatient admission or ED visit.

C. Proposed Outcome Measures

In order to reduce hospital utilization by patients active with community-based providers, MBHS proposes using HEDIS measures related to rapid follow-up after hospital discharge or ED visit. Using DBM's Managing for Results performance for the public behavioral health system where available, or NCQA Medicaid MCO performance, MBHS suggests negotiating a rate of improvement in HEDIS measures among participating providers with automated data exchange.

DBM Managing for Results Performance	**Baseline**
Percent of PBHS service recipients with primary MH diagnosis readmitted to inpatient hospital within 30 days of discharge	14.1% for PBHS in FY2023 Source: DBM, FY25 MFR for BHA, Obj. 1.1
Percent of PBHS mental hospital inpatient recipients with follow-up care within 7 days of discharge	50.2% for PBHS in FY2023 Source: DBM, FY25 MFR for BHA, Obj. 2.6
Percent of PBHS MH recipients with 3+ behavioral health-related ED visits	0.8% for PBHS in FY2023 Source: DBM, FY25 MFR for BHA, Obj. 4.2
HEDIS Performance	
HEDIS Measure: Follow-up within 7 days of ED visit for mental illness (FUM)	40% for Medicaid MCO in 2021 Source: NCQA
HEDIS Measure: Follow-up within 7 days of ED visit for alcohol and other drug abuse or dependence (FUA)	13.4% for Medicaid MCO in 2021 Source: NCQA

D. Alternative Measures

Relying on HEDIS measures for VBP performance may narrow the population significantly. Among the 3,989 active patients with a hospital discharge, the CRISP discharge diagnosis was left blank for 2,896 patients (73%), which would result in the exclusion of 2,896 active patients with a hospital visit from the HEDIS performance measure. The VBP legislation requires a pilot with a minimum of 500 patients, and excluding blank diagnostic fields would still yield over 1,000 patients. However, because use of the above HEDIS measures would result in an undercount of the impacted population, MBHS offers several alternative outcome measures for consideration below.

MBHS can identify high utilizers among the active patients in its connected provider network and work with MDH to incentivize providers to reduce hospital utilization. The 3,989 patients with a hospital visit in CY2023 averaged 3 visits per patient. Focused work to reduce the aggregate hospital utilization among these 3,989 patients, or a portion with multiple visits, may be one approach to the VBP pilot. Diagnostic categories and specific diagnoses on discharge data can help providers identify patients with avoidable or preventable ED utilization.

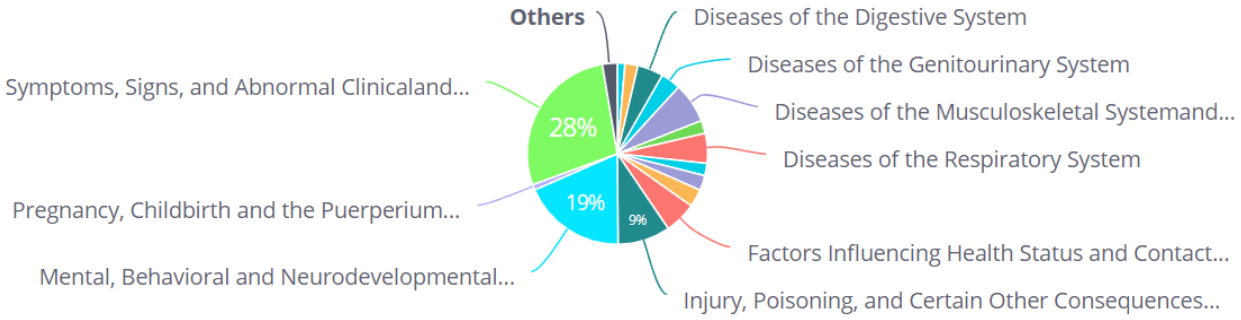
Avoidable ED Visits

In CY2023, patients in active treatment with connected providers were seen in Emergency Departments for:

- 66 visits due to homelessness
- 54 visits for prescription refills
- 12 visits due to “malingering”

Alternatively, VBP measures could incentivize connected providers to reduce hospital utilization across a defined spectrum of eligible diagnoses, including somatic diagnoses. Behavioral health-related diagnosis make up a minority of the ED visits among patients active among the MBHS connected providers, with mental health conditions contributing to 19% of hospital visits and SUD-related causes contributing another 9%. Chronic health conditions like diabetes and social determinants of health like homelessness are prevalent across the hospital discharge diagnoses. Using its data warehouse to establish current performance benchmarks, MBHS can work with MDH to define incentives for connected providers to reduce hospital utilization among defined diagnoses within the eligible patient cohort.

Figure 1 – NCHS diagnostic categories on hospital discharge encounter for MBHS CRISP-connected provider active patients, CY2023



How a VBP Pilot Could Work

Once the patient cohort and performance measures have been identified, providers will submit fee-for-service billing as normal and receive a $100 PMPM for care coordination, data analytics and more flexible, enhanced outreach for the patient cohort. MBHS can report performance to MDH monthly or quarterly. Payments will be reconciled with performance incentives annually over the course of the three-year pilot.