COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

HMA Presentation Feedback

1. We've outlined five necessary steps for behavioral health benefit management. Are we missing any critical steps?

   Five steps include:

   1) Clear articulation of policy and operational goals and capacity to carry out implementation.

   2) Stakeholder engagement.

   3) Provision of fiscal incentives to providers.

   4) Balance network management with collaboration with MCOs (and other providers).

   5) Identify metrics to assess improvements in healthcare access, quality, and outcomes.

The presentation was clear that integration in Medicaid managed care was associated with greater access to outpatient behavioral health services for individuals with *MILD AND MODERATE MENTAL HEALTH CONDITIONS* and that initially, individuals were less likely to access psychiatrists and other behavioral health specialists, and access DID NOT INCREASE for individuals with severe and persistent mental illness. A critical step in evaluating ANY proposed model should include a thorough examination of WHO is covered and WHAT services are covered. Many services including team-based care (ACT/Mobile treatment, IOP etc.) would not be covered in a fully integrated system of care, individual who are dually eligible for Medicaid and Medicare would not be covered, and individuals who are uninsured would lose access to treatment.

2. What are the strengths and challenges of the current behavioral health ASO model in Maryland?

STRENGTHS of the current behavioral health ASO model include:

- **The current model offers a higher treatment penetration rate (18%) compared to states with a carve-in or similar model (8%)**
- **Individuals in need of services have access to full continuum of care and services.**
- **Individuals have access to the full Medicaid drug formulary under the ASO model, in a carve-in or similar model, each MCO could dictate its own covered drugs leading to individuals losing access to medications that have managed their symptoms for years.**
- **Braided funding to cover non-Medicaid covered services like group homes.**
- **Funding braids to cover dual eligibles, individuals over age 65, individuals who are uninsured.**

- **Team based services such as Crisis Intervention, Mobile Crisis, ACT, Peer Support, Case Management and IOP are covered.**
- **Transparent and publicly available payment structure and reimbursement rates – MCOs are unwilling to share rates, numbers served, etc. saying this information is "proprietary."**
- **Credentialing is through a single point of contact, and having a single point of contact means regulations are applied consistently, and problems can be more efficiently identified and resolved.**
- **ASO provides a single point of contact for authorizations, billing, customer support.**
- **Availability and ownership of data. Data belongs to stakeholders, and they can access as needed.**

CHALLENGES of the current behavioral health ASO model include:

- **Lack of budget predictability**
- **Any willing provider network.**
- **Lack of quality providers**
- **Failure to implement value-based approaches or incentives for quality care and outcomes.**
- **Many of the significant problems are specific to the current ASO and its inability to deliver what was promised in its proposal.**
    - **Procurement – always going with the "cheapest" proposal – gets what you pay for in most cases.**
    - **Inadequate and poorly trained staff. Providers reporting multiple contacts needed to address a single issue.**
    - **Lack of oversight from MDH**
    - **Failure to demand contract deliverables – Optum failed from the beginning, yet the providers were forced to bear the financial and administrative burden.**
- **Changing systems frequently can lead to problems in implementation and contract management – Optum has been a disaster since launch – ASO contract is 4 years with a fifth-year option, an examination of how contracts are awarded would be beneficial.**
- **Performance is dependent on the contract holder and can fluctuate with each contract. MDH should avoid consistently selecting the LOWEST bid.**

3. How might a different behavioral health management model address the challenges of the current system?

CBH of Maryland acknowledges that the current system needs an overhaul. We oppose a carve-in model and know that integration is already happening within the current ASO model at many levels. For example, there are 7 CCBHCs operating across the state, providers have co-located primary care and pharmacy services, and operate Health Homes. Changes to the current model should enhance what is already being done to support integration and could include:

- **Incentives for achieving desired health outcomes.**
- **More provider accountability through payment structures like CCBHCs and Value Based Purchasing**
- **Bidirectional – integration doesn't just mean Primary Care to include Behavioral Health, but looking at programs like Health Homes where somatic care is integrated into Behavioral Health and CCBHCs where wholistic care is an expectation.**
- **Data sharing – data should be shared across payors could have more consistent data – this– MCOs have historically refused to share their rates, numbers served, and outcomes claiming it is proprietary. In a system where providers are contracting with multiple MCOs this would be a disaster.**

4. If the State were to consider changes to the current ASO model, what would be the major challenges to implementing a different model?

We are unable to answer this as is it premature to consider any changes to the current model without first fully understanding and setting policy goals and ensuring robust stakeholder engagement.

5. What role would your agency or organization play in implementing a different model, and how would this impact your current operations?

It is the role of CBH of Maryland to work with members and stakeholders in understanding and adapting to any changes. It is also our role to advocate with legislators to ensure individuals who depend on community providers for their behavioral health needs are not left in a position where access is limited or challenged. The majority of individuals with severe and persistent mental illness and those with substance use disorders do NOT get care in Primary Care settings, but in community behavioral health settings. If the model increases access for mild/moderate but decreases access to SPMI even if it evens out over time, that is unacceptable and CBH will advocate against any model that decreases access to care.