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August 14, 2020

Cynthia Petion
Deputy Director, Systems Management
Behavioral Health Administration

Dear Ms. Petion:

I am writing to provide feedback on the draft BHA State Plan as the representative of the Community Behavioral Health Association of Maryland (CBH) to the Behavioral Health Advisory Committee (BHAC).

CBH represents 75 organizations, encompassing virtually every provider type and program service in the public mental health system. Collectively, our members report serving about 180,000 individuals annually, or roughly 80% of the individuals receiving publicly funded mental health services in FY2019.

Our feedback is below:

GOAL 2: IMPROVE QUALITY OF CARE IN THE PUBLIC BEHAVIORAL HEALTH SYSTEM

P. 16-17; Strategy 2.2 I, J and K:

CBH fully supports BHA's overall efforts to ensure high quality care and good patient outcomes as well as fiscally responsible service use, especially in light of the constraints posed by COVID-19 on the Medicaid budget.

Maryland has been plagued by the costly use of higher levels of care at dramatically higher rates than many other states. Nationally, less than 1% of children using publicly funded services are admitted to state psychiatric hospitals, inpatient hospitals, or residential treatment centers. In Maryland, an astonishing 13% of children in the public behavioral health system are admitted to such settings annually.¹ Strategy 2.2K's intent to divert children from non-therapeutic settings such as emergency rooms to the least

¹ See SAMHSA, "Maryland 2019 National Outcome Measure (NOMS): SAMHSA Uniform Reporting System," at p. 16 (reflecting 4,905 (13%) admissions to state psychiatric hospitals, inpatient units, or residential treatment centers, with 33,607 (85%) admissions to community placements for Maryland children, compared to national admissions of 86,149 to hospital or RTC (0.9%) annually, against 10,113,081 community admissions (99%).

restrictive community-based settings appropriate for their care is laudable, as is Strategy 1.1D's focus on the expansion of crisis response and assessment services to be used to facilitate that diversion.

However, the siloed strategy of targeting a 10% reduction of child PRP services (Strategy 2.2i1), without regard for appropriate clinical necessity nor consideration of the adequacy of the broader continuum of care to serve the children for whom this service will be eliminated, seems destined to undermine both the effort to decrease the rate of emergency room utilization as well as the capacity of community providers to accept the referrals made by a new crisis response team.

Maryland's intensive home and community-based services including targeted case management (TCM), 1915(i), and respite care – services explicitly designed to divert children from higher levels of care – are all vastly underutilized, having served 2%, 0.3%, and 0.05% of PBHS eligible children respectively in FY18 (most recent available data). This is almost certainly contributing to the high utilization of both PRP (16.5%), as well as particularly costly inpatient services (7%) and emergency rooms (11.8%).² These rates of service utilization point to the fact that children requiring intermediate levels of care – supports beyond outpatient services provided in the community – are almost wholly reliant on PRP, and to a lesser extent, TCM.

CBH suggests then, that Strategy 2.2 I, rather than targeting a specific reduction in child PRP utilization, undertake policy actions to address known barriers and under-utilization of intermediate levels of care (TCM, Respite, 1915(i)) including restrictive eligibility criteria, cumbersome enrollment processes and reimbursement rates that make it impossible to scale up a business model, in order to ensure the regional availability of a range of community-based intermediate services and to facilitate Strategy 2.2k's goal of a 10% reduction in ER utilization.

CBH shares BHA's concern with the proliferation of low quality and fraudulent PRPs, but urges BHA to consider alternatives that are target-specific in their enforcement and deterrent efforts – strategies which would not decrease access to vital services for children and jeopardize the operational stability of quality providers. These might include:

- Require the LBHAs to conduct on-site visits for all new applicants for PRP-M licensure;
- Enforce existing administrative and business requirements including Good Standing with the State of Maryland, etc.
- Require the ASO to review claims history during a PRP authorization request and, if the child does not have current therapy claims, require the provider to submit additional evidence of medical necessity;

² See "Health-General § 7.5–209—Report on Behavioral Health Services for Children and Young Adults," Utilization of PBHS Services, pp. 9-18.

- Where utilization or auth practices by a PRP-M provider raise concerns, require the ASO to subject the provider to a more frequent authorization schedule and require additional evidence of medical necessity;
- Publish a report annually, available to stakeholders, with data about the utilization of each child service in the public behavioral health system

P. 18 -- GOAL 3: IMPROVE COORDINATION OF CARE

OBJECTIVE 3.1 - Develop and Utilize an Integrated Systems Management Approach

Strategy 3.1A In collaboration with Medicaid (MA), monitor and evaluate the performance of the administrative service organization (ASO), requiring improvement as needed.

We recommend that the performance measures be modified to more clearly track the reporting requirements required by the ASO vendor, and to clearly delineate when and how those reports will be available to stakeholders. Given the vendor's current performance and impact on the functioning of the public behavioral health system, improved transparency on the vendor's performance and the state's monitoring can provide stakeholders with better understanding and confidence in state oversight.

Specifically, the behavioral health state plan should describe when and how the following required reports by the ASO vendor will be made available to the public:

- An annual strategic plan to increase provider enrollment and describe its performance in doing so (p. 15, 2.3.2.3). This should include geo-mapping to identify service availability and gaps (p. 16, D) and action plans in collaboration with LBHAs (p. 16, H).
- ASO compliance reports on contract requirements to:
 - Respond to provider inquiries within one business day (p. 16, 2.3.2.4.A);
 - Resolve claims problems and open tickets within same week or report to Contract Monitor (p. 16, 2.3.2.4.A.5).
 - Resolve provider problems within one week or report delays to contract monitor (p. 16, 2.3.2.4.A.7).
 - Track timeframe for provider problem resolution and share with MDH (p. 16, #11)
 - Have sufficient staff to track and monitor provider complaints (p. 32, #6).
- The vendor's monthly reports evidencing the attained level for each service-level agreement (p. 67, 2.6.4), including call center pick-up performance, claims processing performance, notice to providers of claims unable to process, any root cause analyses completed, and any financial penalties leveraged by the state.
- The ASO vendor's performance on quality measures, including:
 - Follow-up appointment after hospital discharge (excluding SUD residential)
 - Mental health re-admission rate
 - Engagement of newly diagnosed set of SUD & MH in treatment
 - Med adherence for schizophrenia
 - Med adherence for antidepressants

ADD Strategy 3.1D Language: Establish Effective Communication and Planning Mechanisms Across Children’s Systems

We suggest that BHA add language to its state plan to address cross-system communication for children’s systems. Children with behavioral health needs are served by a complex web of public systems, however, decisions pertaining to the role of those systems in a child’s care are commonly made in silos. CBH’s child-serving members often face clinical, financial and operational challenges arising from the absence of a coordinated approach to ensuring appropriate housing, schooling and behavioral healthcare are provided to their child clients, especially to foster children and children with the highest acuity behavioral health needs. CBH members would like to see and contribute to a statewide effort to establish effective cross-system (BHA, DHS, DJS, MSDE) communication, policy development, service delivery and payment structures for child-serving programs.

We appreciate your attention to these concerns. If you need additional information, do not hesitate to reach out to Lauren Grimes, Assistant Director, at lauren@mdbh.org or me at shannon@mdbh.org.

Sincerely,



Shannon Hall, J.D.
Executive Director