MARYLAND DUALS INITIATIVE:

RECOMMENDATION FOR STRONG BEHAVIORAL HEALTH PERFORMANCE | 2016

Throughout 2016, the Community Behavioral Health Association of Maryland (CBH) and its representatives have participated in DHMH's planning to develop an innovative model of care for Maryland's dual eligible. This briefing summarizes recommendations offered by CBH to ensure that the duals' innovation model supports strong, effective deployment of behavioral health services.

A. STRUCTURAL COMPONENTS OF ACCOUNTABLE CARE MODEL

1. REQUIRE THAT ALL DUALS ACOS HAVE AT LEAST ONE COMMUNITY BEHAVIORAL HEALTH ORGANIZATION IN A GOVERNANCE POSITION, AS WELL AS OTHER HEALTH CARE AGENCIES THAT SPECIALIZE IN SERVING OTHER DIAGNOSES WHICH DATA REVEAL ARE ASSOCIATED WITH THE TOP TEN PERCENT OF HIGH COST USERS.

One of the best ways to ensure that individuals with behavioral health conditions receive the care they need is to ensure that historic behavioral health providers who have long served this population have a seat at the governing table – and equal voting rights with other governing members – in any ACOs established under this program. All too often, behavioral health conditions have taken a back seat to other somatic conditions in clinical, structural, and financing arrangements. Given the long history of behavioral health receiving short shrift in our healthcare system, and the fact that the duals population consists of a large percentage of individuals with behavioral health conditions, CBH strongly urges adoption of this recommendation.

Because individuals with severe mental illness (SMI) make up such a large portion of high-cost duals, it is essential that the Duals Initiative meet the needs of this population. Requiring the participation of community behavioral health providers in the governance of ACOs can help ensure that program and payment design is integrated and designed appropriately for the SMI population throughout the organizational structure.

2. IF AN ACO MODEL IS ADOPTED WITH THE PROVISIONS RECOMMENDED BY CBH, TEST THE MODEL'S EFFICACY IN A SMALL AREA BEFORE ADOPTING WIDESPREAD EXPANSION. THE TESTING OF THE MODEL SHOULD INCLUDE CLEAR OUTCOME MEASURES TARGETED TO ADDRESSING THE HEALTHCARE DISPARITY EXPERIENCED BY INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS.

We have grave reservations about the use of an ACO model for populations with high behavioral health needs. There is no tested model in the country that uses an ACO design for a Duals Initiative. Moreover, our research suggests that no ACO is effectively managing behavioral health risk and successfully taking payment reform to the provider level. Maryland runs the risk of creating major clinical and financing upheaval for one of our state's most vulnerable populations at a time when the state's community and state psychiatric hospitals have little margin for error.

No matter how well Maryland designs and prepares for this initiative, there will be some negative consequences and fall-out from the disruption of change. Given the state's deepening opioid crisis, forensic hospitalization crisis, and overall need to reduce hospitalizations, we recommend the use of a pilot ACO program (assuming the ACO includes a community behavioral health organization at the governance level) that includes strong behavioral health outcomes and monitoring of same.

When the ACO model as recommended by CBH is fully tested and its negative consequences have been ameliorated with less vulnerable populations, Maryland should consider a phased roll-out in other areas.

B. STRUCTURAL COMPONENTS OF BOTH ACO AND MFFS MODELS

3. THE ALLOCATION PROCESSES AT BOTH LEVELS (ATTRIBUTION TO AN ACO OR MFFS REGIONAL ENTITY, AND THEN ATTRIBUTION TO A PCHH) SHOULD MAINTAIN EXISTING RELATIONSHIPS WITH CHRONIC HEALTH HOMES OR PERSON-CENTERED MEDICAL HOMES, TO THE EXTENT POSSIBLE. BECAUSE THE ESTABLISHMENT OF A TRUSTING RELATIONSHIP IS A CORNERSTONE OF EFFECTIVE BEHAVIORAL HEALTH TREATMENT, ALL EFFORTS SHOULD ALSO BE MADE TO KEEP INDIVIDUALS WITH THEIR BEHAVIORAL HEALTH PROVIDERS, SUCH AS OUTPATIENT MENTAL HEALTH CENTERS, EVEN IF THOSE PROVIDER TYPES ARE NOT ELIGIBLE TO BE HEALTH HOMES UNDER MARYLAND'S CURRENT PLAN.

For those with a serious mental health or substance use disorder diagnosis, the clinicians and programs providing behavioral health treatment and supports are "primary care providers" who not only deal with the diagnosis and treatment issues, but also address the social determinants of health that so often

make the difference between successful health outcomes and reliance on emergency departments and inpatient settings.

4. CAPITALIZE ON, AND INTEGRATE IN, THE RESOURCES, EXPERTISE AND INFRASTRUCTURE OF THE MARYLAND MEDICAID HEALTH HOME PROGRAM BY ALLOWING – AND ENCOURAGING -- DHMH-APPROVED HEALTH HOMES TO BE PERSON-CENTERED HEALTH HOMES (PCHH) IN BOTH THE MANAGED FEE-FOR-SERVICE (MFFS) AND ACCOUNTABLE CARE ORGANIZATION (ACO) MODELS.

As the research data revealed when presented to the Duals Committee, psychosis is the diagnosis in the Dual population that is associated with the highest medical costs. The most significant barriers to the physical health of individuals with serious mental illness (SMI) or substance use disorders (SUD) emanate from the behavioral health disorders (e.g. lack of motivation and/or skills to comply with treatment recommendations, manage chronic diseases, and maintain healthy lifestyles). Community behavioral health agencies have the greatest expertise to address these barriers -- and have the closest relationships to leverage which is one of the most critical means of behavior change. This is one of the major reasons why so many states, including Maryland Medicaid, have chosen these agencies to be the health homes for people with SMI or SUD. That is the same reason why the Duals Initiative should follow the same path. Washington State did this, braiding funding from the Medicaid Chronic Health Home Option with funding from their Duals Initiative, and having community behavioral health agencies serve as PCHHs for both populations within a MFFS design.

5. ONE WAY TO ENCOURAGE NUMBER 4 ABOVE IS TO ALLOW DHMH APPROVAL AS A HEALTH HOME TO ACT AS DEEMED STATUS FOR THE APPROVAL OF PCHHS.

All Medicaid Health Homes must be nationally accredited under standards for Health Homes or Patient-Centered Medical Homes. It would be a waste of public and nonprofit private resources to require an additional approval process for participation in the Duals Initiative, and this unnecessary duplication of requirements could create a disincentive for Medicaid Health Homes to participate as PCHHs.

6. IN ADDITION TO NUMBER 4 ABOVE, FURTHER CAPITALIZE ON THE INFRASTRUCTURE OF THE MEDICAID HEALTH HOME PROGRAM BY ENCOURAGING MEDICAID-APPROVED HEALTH HOMES TO EXPAND THEIR STAFFING AND SERVICES, USING SIMILAR STANDARDS AND INTERVENTIONS, TO SERVE INDIVIDUALS WITH SMI OR SUD ARE NOT CURRENTLY IN MEDICAID HEALTH HOMES (I.E. NOT ELIGIBLE FOR PSYCHIATRIC REHABILITATION, ASSERTIVE COMMUNITY TREATMENT, OR OPIOID TREATMENT PROGRAMS).

Our members' data suggests that many of their clients with the most frequent hospital admissions are enrolled in outpatient behavioral health programs, not PRP, ACT or OTP. These individuals are ineligible to receive health home services that expand their somatic care management. Given co-morbidities and inefficient health care utilization among this population, extending health home eligibility to duals with SMI/SUD receiving outpatient behavioral health services may yield significant benefits.

7. ALLOW PCHHS UNDER BOTH MODELS TO SHARE COST SAVINGS AT SOME LEVEL.

This recommendation is important, not only to incentivize PCHHs to "go the extra mile" to meet the goals of the program, but also to allow PCHHs to reinvest in successful interventions.

8. ENSURE THAT OUTCOME MEASURES REFLECT THE SPECIFIC NEEDS OF THOSE WITH BEHAVIORAL HEALTH CONDITIONS.

The data clearly show that individuals with behavioral health conditions die younger than the general population, and contribute disproportionately to the unnecessary utilization of emergency department and inpatient care. Unless this redesign pays close attention to the needs of this population, those unfortunate trends will continue. CBH appreciates the desire to avoid additional outcomes collection and to standardize outcomes across payers and programs. However, the data speak for the need to focus on outcomes specific to those with behavioral health conditions.

C. RECOMMENDED COMPONENTS OF QUALITY, RATES, AND ROLES

9. QUALITY MEASURES SHOULD INCLUDE HEALTH HOME, HOUSING & EMPLOYMENT MEASURES

DHMH's data indicates that individuals with behavioral health disorders make up a significant portion of high-cost dual eligibles, suggesting that effective management of this population is critical to the success of Maryland's duals initiative. At the same time, there is no tested model in the country that uses an ACO model for the duals initiative. Given the centrality of the behavioral health population and lack of a track record for ACOs in this area, we believe that a strong focus on behavioral health quality measures is warranted.

Despite this need, behavioral health measures are reflected in only four of the fifteen proposed ACO quality measures presented on October 18, 2016 (Oct. 18 slide deck, pp. 11-12). The four measures related to behavioral health are: initiation of drug treatment, depression screening, follow-up after hospitalization for mental illness, and antipsychotic use in persons with dementia.

The proposed quality measures relating to behavioral health lack breadth and focus. We recommend including health home quality measures in the ACO performance goals to improve the breadth of behavioral health performance measure.

The National Quality Forum's "Quality in Home and Community-Based Services To Support Community Living" recommends having "quality measures across all domains" (p. 12). However, the proposed model's quality measures are not focused on the desired performance of the ACO for behavioral health. In particular, the duals ACO model proposes to offer "seamless coordination across health care settings *and spanning to social supports*" (p. 3; emphasis added) and to "foster relationships with community resources to support members" (p. 8). The extent to which an ACO fosters these social supports is the lynchpin of its ability to manage its behavioral health population well – yet the quality measures are absolutely silent on this domain.

We therefore recommending including measures related to this goal. In particular, we recommend measuring:

- Number of members with SMI or functionally limiting SUD who maintain stable housing (as done in the Illinois and Virginia Dual demonstrations); [1]
- Number of members with SMI or functionally limiting SUD who maintain or gain employment (adapted from IOM).

10. CARE PLAN RATES SHOULD ACCOUNT FOR EXTENSIVE OUTREACH TO SMI

Individuals with serious mental illness (SMI) often have unstable living arrangements or are homeless, making it difficult to locate and engage them in care planning. Some are also suspicious of individuals they don't know, and it can take long periods of time before even gaining access to the client to engage in care planning. The rates for initial care plans should account for the difficulty inherent in engaging this population, and should also allow for payment for documented attempts to locate and engage those with serious mental illness.

11. ROLE OF PATIENT-CENTERED HEALTH HOME AND ACO IN CARE COORDINATION AND CASE MANAGEMENT

[1] National Council for Behavioral Health, "Ensuring Access to Behavioral Healthcare Through Integrated Managed Care: Options and Requirements" (2014 Update); available at: https://www.thenationalcouncil.org/wp-content/uploads/2014/11/14_Managed-Care-2.pdf.

All Care Coordination and Care Management should be performed by the person-centered health home (PCHH), not the ACO. First of all, there is no bright-line difference between care coordination and care management – both are clinical processes that involve outreach, engagement, assessment, care plan development, care plan implementation, and on-going evaluation and monitoring.

As the data revealed when presented to the Duals Committee, psychosis is the diagnosis in the Dual population that is associated with the highest medical costs. The most significant barriers to the physical health of individuals with serious mental illness (SMI) or substance use disorders (SUD) emanate from the behavioral health disorders (e.g. lack of motivation or skills to comply with treatment recommendations, manage chronic diseases, and maintain healthy lifestyles). Community behavioral health organizations have the greatest expertise to address these barriers -- and have the closest relationships to leverage, which is one of the most critical means of behavior change. This is one of the major reasons why so many states like Maryland followed the model developed by Missouri Medicaid (which saved over $30 million -- $98 PMPM) and chose these organizations to be the health homes for people with SMI or SUD.

For these reasons, it is imperative that the Duals Initiative not take a step back from this innovation and start to pull back up the chain, further away from the consumer, any care management or care coordination functions. At the end of the day, for individuals with SMI and SUD, it is all about the relationships that need to be leveraged. An ACO will not have those relationships. And to duplicate care coordination and care management functions between the ACO and the PCHH will only add confusion and dilute the effectiveness of the service.

This is a population of people who are frequent utilizers of higher levels of care because their particular illnesses are internally fragmenting, and they have historically fallen through cracks in fragmented systems of care. To fragment care coordination and care management functions between the ACO and the PCHH will only exacerbate the problems that have driven their high medical costs.