

**Continuation of Behavioral Health
Integration
Proposal to the Centers for Medicare
& Medicaid Services**

**Submitted by
Maryland Department of Health**

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Maryland Proposal Plan

Continuation of Behavioral Health Integration

Overview

Effective January 1, 2017, the Centers for Medicare and Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a period of five years. As part of the waiver, the Maryland Department of Health (the Department) committed to developing a strategy to integrate physical and behavioral health care services in order to improve health outcomes for beneficiaries with substance use disorder (SUD) in the Maryland Medicaid Program. CMS requires the Department to produce a concept design for an integrated care model by July 2018, with the goal of implementing physical and behavioral health integration by January 1, 2019.

To date, the Department has engaged in a variety of strategies designed to improve the integration of behavioral health services in the State. These include:

- Implementing individual Release of Information (ROI) forms from Medicaid participants accessing SUD services through the behavioral health administrative services organization (ASO) to facilitate data sharing with the HealthChoice managed care organizations (MCOs);
- Introducing new guidance on the provision of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to encourage Medicaid providers to incorporate screening into their practices; and
- Continuing support for and evaluation of the Health Homes established in October 2013 under Section 2703 of the Affordable Care Act (ACA).

The Department has identified several areas of focus for continued improvement in the near-term—these include, implementation of performance-based metrics for the ASO, consideration of a Collaborative Care Pilot, potential expansion of the provider types eligible to participate in the Health Home Program, continued support for the development of ‘Consent2Share’ software by the state health information exchange (HIE), and launch of the Assistance in Community Integration (ACIS) Pilot Program. Additionally, one of the limitations of the current fee-for-service model is that payment is not tied to individual provider performance. In the long-term, the Department also intends to focus on opportunities to introduce value-based payments to the delivery and coordination of behavioral health services at a provider level.

Provision of Behavioral Health Services in Maryland

Following a multi-year stakeholder process to streamline the existing disparate systems of care for individuals with co-occurring serious mental illness and substance use issues, the Department elected to carve-out SUD service from its HealthChoice benefits package. Effective July 1, 2014, the Mental Hygiene Administration (MHA) and Alcohol and Drug Abuse Administration merged to become the Behavioral Health Administration (BHA). An administrative services

organization (ASO) was selected in September 2014 to coordinate behavioral health care for both Medicaid participants and the uninsured. Since January 1, 2015, all specialty mental health and SUD services for Medicaid recipients have been administered by the ASO.

Initiatives Underway to Support Behavioral Health Integration

Since implementing the SUD carve-out, the Department has engaged in a variety of initiatives designed to improve the integration of behavioral health services for Medicaid participants. These efforts include implementing individual release of information (ROI) forms from Medicaid participants accessing SUD services through the ASO to facilitate data sharing with the MCOs; introducing new guidance on the provision of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to encourage Medicaid providers to incorporate screening into their practices; and continuing support for and evaluation of the Health Homes established in October 2013 under Section 2703 of the ACA.

Individual Release of Information Data Sharing

The Department recognizes that the establishment of a bifurcated health care delivery system has created certain challenges with respect to data sharing. The use and disclosure of protected health information (PHI) is governed, generally, by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, PHI may be disclosed for purposes of treatment, payment and health care operations without patient consent. However, in nearly all cases, the disclosure of drug and alcohol use (SUD) treatment and prevention records is subject to the more restrictive and stringent standard of 42 C.F.R. Part 2 (“Part 2”), which prohibits the disclosure of PHI absent specific authorization from the patient.

Prior to the implementation of the carve-out, as the payers of SUD claims, Medicaid MCOs had limited access to data otherwise protected by Part 2. However, an MCO’s ability to re-disclose this information to a patient’s somatic care providers or for care coordination purposes was still subject to Part 2’s guidelines and thus required express consent from the patient. When SUD services were carved out of the MCO benefit package in 2015, the Department established a process to obtain individual ROI forms from Medicaid beneficiaries accessing SUD services. Completed forms allow the ASO to release authorization and claims data to the enrollee’s MCO—along with additional providers specified by the patient—and thereby coordinate care across the continuum of care. All SUD programs and providers—as well as mental health providers delivering SUD services to Maryland Medicaid members—have been instructed to request an ROI form prior to the provision of SUD services. Since the implementation of behavioral health integration, approximately 90 percent of participants in each MCO have consented to sharing their information. The consent form is required to be updated by the patient annually.

Additional opportunities to improve data sharing will be discussed in the next section.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The Medicaid Program introduced new guidance on the provision of SBIRT to encourage Medicaid providers to incorporate screening into their practices in July 2016. The guidance included clarifications on the provider types eligible to bill for services, billable services, and new coding and reimbursement guidelines.¹ The Department reimburses a billing provider for one screening and up to four interventions per recipient aged 12 years and older annually. SBIRT billing codes are listed in Table 1.

Table 1. SBIRT Billing Codes

Procedure Code	Description
99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
W7000*	Alcohol and/or substance (other than tobacco) use disorder screening; self-administered
W7010*	Alcohol and/or substance (other than tobacco) use disorder screening; provider-administered structured screening (e.g., AUDIT, DAST)
W7020*	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 3 minutes up to 10 minutes
W7021*	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 10 minutes up to 20 minutes
W7022*	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 20 minutes

**New codes introduced effective July 1, 2016*

Chronic Health Home Program

The Affordable Care Act (ACA) created the option for state Medicaid programs to establish Health Homes. In response, the Department began the Chronic Health Home Initiative in October 2013. The program is focused on Medicaid participants with a serious and persistent mental illness (SPMI), an opioid SUD and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use, and children with serious emotional disturbance (SED). Individuals can participate in Health Homes if they are eligible for and engaged with a psychiatric rehabilitation program (PRP), mobile treatment service (MTS), or an opioid treatment program (OTP) that has been approved by the Department to function as a Health Home provider.

¹ PT 43-16, General Provider Transmittal No. 82, Medicaid Program Updates for Spring 2016, issued June 6, 2016, https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_43_16_edicaid_program_updates_for_spring_2016.pdf. PT 45-16, Free-Standing Clinic No.7, Screening, Brief Intervention, and Referral to Treatment, issued June 8, 2016, https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_45-16_SBIRT.pdf.

Health Homes offer participants enhanced care coordination services from providers with whom they regularly receive care. Health Homes are designed to enhance person-centered care, empower participants to manage and prevent chronic conditions in order to improve health outcomes, and reduce costs and avoidable hospital encounters.

Health Homes provide six core services, as follows:

- Comprehensive Care Management,
- Comprehensive Transitional Care,
- Care Coordination,
- Individual and Family Support,
- Health Promotion, and
- Referral to Community and Social Support.

Participating Health Homes receive an initial intake and assessment fee of \$102.87 when they enroll a new individual into the program. Health Home providers are also eligible for a \$102.87 monthly rate per participant for each month in which an enrollee receives at least two qualified Health Home services. If an enrollee receives fewer than two services, the Health Home is not eligible to receive a payment for that individual for that month. Health Home services include care coordination, care management, health promotion, and referrals to community and social support services. The State received a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the provision of Health Home services during the first eight quarters of the program.

To date, the Department has produced two evaluations of the Chronic Health Home model.^{2,3} A third report evaluating outcomes of the first three years of the program will be complete in Fall 2018. As detailed in Tables 2 and 3, preliminary analysis suggests that longer term enrollment in the health home is associated with reductions in both emergency department (ED) and inpatient utilization.

Table 2. Utilization Rates per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any ED Visit	Percentage of ED Utilization	Number of ED Visits	Average ED Visits per Participant
0 to 6 Months	8,526	3,367	39.5%	8,769	1.03
7 to 12 Months	6,656	2,358	35.4%	5,749	0.86
13 to 18 Months	5,011	1,669	33.3%	3,960	0.79
19 to 24 Months	3,738	1,183	31.6%	2,955	0.79
25 to 30 Months	2,782	886	31.8%	2,215	0.80
31 to 36 Months	2,149	474	22.1%	1,514	0.70
37 to 42 Months	1,151	175	15.2%	338	0.29

² 2015 Joint Chairmen’s Report on Patient Outcomes for Participants in Health Homes, <https://mmcp.health.maryland.gov/Documents/JCRs/chronichealthhomeJCRfinal11-15.pdf>.

³ 2016 Health Home Evaluation Report, https://mmcp.health.maryland.gov/SiteAssets/SitePages/Health%20Home%20Program%20Evaluation%20and%20Outcomes/health_home_2016_evaluation_report.pdf.

Table 3. Inpatient Utilization Rates per Participant, by Length of Enrollment

Length of Enrollment	Total Participants	Number with Any Inpatient Visit	Percentage of Inpatient Utilization
0 to 6 Months	8,526	1,062	12.5%
7 to 12 Months	6,656	784	11.8%
13 to 18 Months	5,011	502	10.0%
19 to 24 Months	3,738	413	11.0%
25 to 30 Months	2,782	275	9.9%
31 to 36 Months	2,149	202	9.4%
37 to 42 Months	1,151	61	5.3%

Based on these results, the Department recognizes the importance of giving the Chronic Health Home Program more time to mature as a program before drawing conclusions about its effectiveness and believes more implementation time is needed for the model.

Next Steps for Behavioral Health Integration

The Department has identified several areas of focus for continued improvement in the near-term—these include

- Implementation of performance-based metrics for the ASO,
- Development of a Collaborative Care Pilot,
- Potential expansion of the provider types eligible to participate in the Health Home Program and other alterations to bring the program into alignment with Maryland’s Total Cost of Care All-Payer Model,
- Continued support for the development of ‘Consent2Share’ software by the state health information exchange (HIE),
- The launch of the Assistance in Community Integration (ACIS) Pilot Program, and
- The expansion of residential treatment for SUD under the §1115 demonstration waiver amendment.

In the long-term, the Department also intends to focus on opportunities to introduce value-based payments to the delivery and coordination of behavioral health services at a provider level.

Implementation of ASO Performance Measures

One overarching goal of the behavioral health integration effort was to implement performance-based standards for the ASO. The current contract with the ASO originally included outcome-based standards based on six HEDIS measures:

- Antidepressant Medication Management (AMM);
- Follow-up Care for Children Prescribed ADHD Medication (ADD);
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA);
- Mental Health Utilization (MPT);

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET); and
- Plan All-Cause Readmissions (PCR).

The ASO was unable to meet the required HEDIS deliverables, as the ASO did not have access to the necessary somatic data. In addition to data sharing obstacles, the Department further identified that certain measures could not be assessed accurately. For example, the original performance metrics assumed a percent change for each month over a twelve month period. However, MMIS2 data are not considered complete until 12 months have passed for submission of fee-for-service (FFS) claims and six months for submission of managed care organization (MCO) encounters, which would create challenges assessing changes on a monthly basis. The Department is in the process of finalizing five new performance metrics for the ASO to replace the 6 HEDIS measures originally included in the current contract.

The new ASO performance measures are as follows:

1. Follow-up After Behavioral Health Hospitalization (Two items will be measured: follow-up appointment after hospitalization within seven (7) and thirty (30) days);
2. Annual Mental Health Readmission Rate;
3. Initiation and Engagement of Newly Diagnosed Consumers with Substance Use Disorder (SUD);
4. Consumers Diagnosed with Schizophrenia and Antipsychotic Medication Adherence; and
5. Adherence of Antidepressant Medication Use for Consumers Diagnosed with Major Depression from Inpatient Hospitalization.

The ASO is developing intervention strategies designed to improve its performance compared to the CY16 baseline year. The period of intervention will be State Fiscal Year (SFY) 2019. The ASO must submit a preliminary report assessing the impact of the first six months of interventions to the Department by March 31, 2019. The final report is due to the Department by October 31, 2019. Should the ASO fall short of the annual targets, liquidated damages will be assessed across each of the five criteria at the updated assessment of .1% not to exceed .5% of the total Contract.

Collaborative Care Program Pilot

Collaborative care is an evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. Collaborative care has been identified as an official evidence-based practice by Substance Abuse and Mental Health Services Administration (SAMHSA) and identified by the Agency for Healthcare Research and Quality as a strong approach for integrating behavioral health treatment.

During the 2018 legislative session, the Maryland General Assembly passed and the Governor approved Senate Bill (SB) 835 (Ch. 683 of the Acts of 2018) entitled *Maryland Medical*

Assistance Program – Collaborative Care Pilot. The bill establishes a Collaborative Care Pilot Program for SFYs 2020 through 2023. Specifically, the bill requires the Department to establish and implement the collaborative care model in up to three pilot sites that deliver primary care services to HealthChoice participants. The Governor must provide an annual budget of \$550,000 for each SFY of the pilot. The bill further stipulates that the Department shall apply to CMS for an amendment to the State’s §1115 HealthChoice Demonstration Waiver if necessary to implement the Pilot Program. Lastly, the Department must report to the Governor and the General Assembly the findings and recommendations from the Pilot Program by November 1, 2023.

Planning efforts for the Pilot implementation are currently underway.

Expansion of Health Home Program Provider Types

Stakeholders have expressed an interest in expanding the provider types eligible to participate in the Chronic Health Home program to include Outpatient Mental Health Centers (OMHC) and other SUD programs. There is also interest in leveraging the Health Homes within the new Maryland Primary Care Program (MDPCP), a core component of Maryland’s Total Cost of Care All-Payer Model. The Department is currently working on its third evaluation of the model, which will assess program outcomes through CY 2016. The Department anticipates publishing this report in Fall 2018.

As the Department learns more about the program’s effectiveness, it will take expanding the Chronic Health Homes to include OMHCs and other SUD programs into consideration. However, the Department anticipates expanding to new provider types could result in a substantial fiscal impact. In SFY16, 104,587 individuals received services from 203 OMHCs.⁴ Assuming 10% to 25% of individuals who received services at OMHCs in FY16 elected to enroll in the Health Home Program, the Department projects the fiscal impact would be an additional \$11M (\$6.6M FF, \$4.4M GF) to \$27M (\$16M FF, \$11M GF) annually.⁵

The Department has also held preliminary discussions with CMMI and CMCS to explore the alignment of the Health Home program with the new MDPCP. The MDPCP, which is slated to launch in January 2019, will attribute Maryland’s Medicare fee-for-service beneficiaries to primary care homes, based on the plurality of their primary care service utilization (similar to the CPC+ program). Due to their unique health needs, the approximately 2,000 Maryland residents dually-eligible for Medicare and Medicaid (dual eligibles) who are enrolled in the Health Home program have been excluded from attribution into the MDPCP. Maryland aspires to create an eligibility pathway for Health Home providers to serve as primary care homes in the MDPCP. Under the envisioned alignment, Medicare would pay the MDPCP-related fees for attributed dual eligibles, and Medicaid would provide the fees for Medicaid-only Health Home participants. MDH, CMMI, and CMCS would work together to develop an enhanced set of

⁴ The number of active OMHCs enrolled with the Maryland Medicaid Program has since grown to 273 as of November 2017.

⁵ Fiscal estimate assumes providers bill for services 85% of the time, consistent with current trends. If overall enrollment increases were more substantial, projected costs would be higher.

requirements for the Chronic Health Homes participating in MDPCP, in support of the integration of behavioral and somatic health services in the Health Home program.

Strategies to Improve the Sharing of Health Information

Presently, efforts are underway on a statewide basis to continue to improve the sharing of behavioral health data through the State Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP). CRISP is developing an open source software application called ‘Consent2Share’, which will allow providers to access behavioral health data through CRISP if they are named in stored patient consents that comply with 42 C.F.R. Part 2. The Department supports the Maryland Health Care Commission’s current rulemaking that will permit CRISP to implement the program.

Assistance in Community Integration (ACIS) Pilot Program

According to a U.S. Department of Housing and Urban Development report, an estimated 26% of homeless adults staying in shelters live with serious mental illness and an estimated 46% live with severe mental illness and/or SUD.⁶ Beginning in August 2017, the Department invited interested lead local government entities to apply for federal matching funds available for the Assistance in Community Integration Services (ACIS) Pilot through a service expansion initiative of the State of Maryland’s Medicaid §1115 HealthChoice Waiver. ACIS Pilot programs provide a set of home- and community-based services (HCBS) to serve high-risk, high-utilizing Medicaid beneficiaries, including those with behavioral health diagnoses, who are at risk of institutional placement or homelessness post-release from certain settings. The ACIS Pilot is capped at 300 individuals statewide annually. ACIS Pilot programs will operate throughout the duration of the §1115 HealthChoice Waiver renewal period, ending on December 31, 2021.

The ACIS Pilot program must be funded and managed by a lead local government entity (Lead Entity), such as a local health department or local management board, with the ability to fund fifty percent of ACIS Pilot costs with local dollars through an intergovernmental transfer (IGT) process. State Medicaid dollars are not available for this initiative. ACIS providers are required to provide a minimum of three services per month to each member to receive reimbursement in a given month. ACIS Pilot services include tenancy-based case management services/tenancy support services and housing case management services designed to improve housing stability, reduce ER visits and inpatient admissions, as well as improve overall health outcomes. Lead Entities will be required to report on performance measures and share data for evaluation purposes in order to receive continued funding.

In Fall 2017, the Department requested and reviewed local applications for federal matching funds for ACIS Pilot programs. In December 2017, the Department announced the award of Round One ACIS Pilot awards to funding to the Cecil County Health Department (CCHD); the

⁶ U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2011). *The 2010 Annual Homeless Assessment Report to Congress*. Retrieved December 12, 2017, from <https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf>.

Baltimore City - Mayor's Office of Human Services (MOHS); and the Montgomery County Department of Health and Human Services (MCDHHS). Up to one hundred ninety (190) individuals out of the statewide total of three hundred (300) ACIS Pilot enrolled individuals were allocated in Round One. The Department completed a second round local application process in Spring 2018 with final awards issued in May 2018. One new award and one supplementary award were granted in the second round application process, fulfilling the three hundred (300) statewide ACIS beneficiary enrollment cap. Prince George's County Health Department (PGCHD) will partner with local organizations to enroll and serve up to seventy five (75) individuals. MCDHHS applied for and was awarded the opportunity to serve an additional thirty five (35) individuals, bringing their grand total award to one hundred and fifteen (115) individuals. Necessary housing stock and rental assistance will be provided through other funding sources, since Medicaid funds may not be used for these purposes.

Based on stakeholder comment, the Department included a request for additional matching federal funds and an increased statewide cap of 600 ACIS enrolled beneficiaries in the recently submitted §1115 HealthChoice Waiver Amendment.⁷

Expansion of Residential Treatment for Individuals with Substance Use Disorders

As part of the §1115 waiver renewal application submitted on June 30, 2016, the Department sought an amendment to authorize Medicaid funds to be used for SUD services in Institutions for Mental Diseases (IMDs). CMS approved this amendment, permitting the Department to expand coverage to include treatment in IMDs. More specifically, the Department applied for expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 to 64 years of age who are enrolled in a Medicaid MCO and reside in a non-public IMD for ASAM Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM (licensed at 3.7D in Maryland). Effective July 1, 2017, the Department provides reimbursement for up to two non-consecutive 30-day stays annually for ASAM levels 3.1, 3.3, 3.5, 3.7, and 3.7WM. The Department intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019 and extend coverage of benefits for dual-eligibles at these levels of care no later than January 1, 2020.

In its recent §1115 HealthChoice Waiver Amendment, Maryland is seeking expenditure authority under §1115(a)(2) of the Social Security Act to claim expenditures by the State for SUD treatment in non-public IMDs for an additional level of care—which are not otherwise included as expenditures under §1903—and to have those expenditures regarded as payments under the State's Title XIX plan.⁸ Specifically, Maryland is requesting expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 through 64 years of age who are residing in a private IMD and have a primary SUD diagnosis and a secondary mental health diagnosis. The Department is seeking to extend coverage for ASAM Level 4.0 (Medically Managed Intensive Inpatient services) for up to 15 days in a month. The days authorized would be based on medical necessity, but would not exceed 15 days per month. For the large cohort of Medicaid adults with co-occurring disorders, private IMDs can deliver specialized services for

⁷ <https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx>.

⁸ *Id.*

participants whose active psychiatric symptoms limit their access to many SUD treatment programs.

Additional Strategies to Improve Integration

While the new performance metrics are designed to improve the ASO's accountability, the current fee-for-service model is not tied to individual provider performance. The Department intends to focus on opportunities to introduce value-based payments to the delivery and coordination of behavioral health services at a provider level. The Department is participating in a technical workgroup sponsored by the SAMHSA-HRSA Center for Integrated Health Solutions that focuses on value-based payment innovation.

Conclusion and Next Steps

The Department remains committed to enhancing the integration of somatic and behavioral health services. In the coming months, the Department will continue to move forward with the physical and behavioral health integration efforts. Areas of focus will include implementation of performance-based metrics for the ASO, consideration of a Collaborative Care Pilot, potential expansion of the provider types eligible to participate in the Health Home Program, continued support for the development of 'Consent2Share' software by the state health information exchange (HIE), and continued support of the Assistance in Community Integration (ACIS) Pilot Program. The Department will also continue to explore opportunities to introduce value-based payments to the delivery and coordination of behavioral health services at a provider level.