One of the recommendations from the Heroin and Opioid Emergency Task Force that is currently underway is a review of Medicaid and other rates provided to SUD treatment providers. This recommendation was based on the fact that the State budget, at the time, had not included a substantial rate increase for these providers in over 10 years. The report stated that making sure that these rates are adequate is considered very important for the treatment community since they need to attract more physicians to the field of SUD treatment at a time when practitioners are in high demand. Without attracting a more thriving workforce and expanded capacity, it was unclear how the availability of the treatment options provided would be able to adequately expand to meet the current demand. However, as of this writing, the review underway is only a comparison of rates with surrounding states, not a review of rate adequacy. **DLS is recommending committee narrative on the adequacy of SUD treatment rates.**

2. Behavioral Health Integration – Furthering Financial and Oversight Alignment

For the past several years, DHMH has been working on the issue of integrating mental health and SUD care. The need to do this was prompted by observations that the previous service delivery system for mental health and SUD services was fragmented and suffered from a lack of connection (and coordination of benefits) with general medical services; had fragmented purchasing and financing systems with multiple, disparate public funding sources, purchasers, and payers; had uncoordinated care management including multiple service authorization entities; and had a lack of performance risk with payment for volume, not outcomes.

As part of the integration process, the State chose to move forward with an expanded carve-out of behavioral health services from the managed care system with added (though limited) performance risk. Specifically, all SUD services would be carved-out from the MCOs and delivered as FFS through an ASO, joining specialty mental health services, which were already carved-out from managed care. The ASO contract includes limited risk for performance against set targets.

Some of the most visible signs of the integration include the merger of the former Mental Hygiene Administration and the Alcohol and Drug Abuse Administration into the newly created BHA, as codified in Chapter 460 of 2014, as well as the reconfiguration of funding streams so that beginning with the fiscal 2016 budget, funds for Medicaid-eligible specialty mental health and SUD services for Medicaid-eligible individuals are located in the Medicaid program, with funding for the uninsured/underinsured and for Medicaid-ineligible services located in BHA. Further, BPW approved a contract for the new ASO, which took effect January 1, 2015.

The ASO is responsible for coordination with both local agencies and the MCOs in order to ensure appropriate referrals from the MCOs and coordination between the MCOs and behavioral health providers. The ASO is responsible for providing additional training to providers in terms of developing and enhancing provider competency in the areas of mental health and SUD services and how to seek authorizations and payments though the ASO.

The ASO contract contains various outcome-based standards, which the ASO will be held responsible for upholding. Beginning with year three of the contract, DHMH is supposed to employ appropriate Healthcare Effectiveness Data and Information Set (HEDIS) measures in order to track the performance of the ASO against other states. There are seven measures, six of which are HEDIS-based, and a seventh that is State-specific. For each measure, the State must be at, or above, the fiftieth percentile (or 70.0% for the State-specific measure). For each outcome standard not met, the ASO will repay to the State 0.0714% of the invoice amounts for the preceding 12 months. Thus, if all seven measures are missed, the total amount of damages is capped at 0.5% of the total contract. The measures to be used include:

- adherence to antipsychotic medications for individuals with schizophrenia;
- follow-up care for children prescribed attention deficit and hyperactive disorder medication;
- antidepressant medication management;
- plan all-cause readmission;
- mental health utilization – inpatient;
- initiation and engagement of alcohol and other drug dependence treatment; and
- the percentage of people in the specialty behavioral health system who have a primary care physician visit within a year (State-specific).

Reporting on these standards was set for the beginning of fiscal 2017, with the average for each outcome standard determined at the end of 2016 and similar averages established each year thereafter. However, DHMH has reported that the ASO was unable to meet the required HEDIS deliverables, as the ASO did not have access to the necessary somatic data. While the ASO indicated that it would require access to all Medicaid claims data, DHMH only provided a more limited data set. The ASO indicated it was not comfortable working with the limited data set. At this time, the ASO has recommended that DHMH waive the liquidated damages associated with the performance measures and is awaiting further guidance from DHMH on this request. DHMH has indicated that they are also considering the possibility of utilizing alternative metrics that the ASO would have access to in order to further evaluate the ASO's performance. **The department should provide an update on what metrics they are considering and why the HEDIS metrics were included in the initial contract if measurement against these metrics was not going to be feasible.**

Financing for SUD Services to the Uninsured

For the most part, the change to a FFS system under an ASO did not require any change to the specialty mental health services for the uninsured since this model is the same as the previous delivery model. However, it created a significant change in the way in which SUD services for the uninsured

are delivered throughout the State. Previously, these services were provided on a grant-based system through the Local Addictions Authorities (LAAs), who then either provided the services themselves or contracted with other providers. With the transition of Medicaid-reimbursable SUD services from the MCOs to the ASO, the SUD grants for the uninsured were the only treatment funds which were not reimbursed by the ASO on a FFS basis. Alignment of financing is a major goal of behavioral health integration, as this change will effectively create treatment on demand for eligible individuals for those services within the FFS model, which is much different from the previous grant-based and managed care system.

The transfer from the grant-based system to FFS for SUD services is now going through a transitional process whereby most services are being transferred to FFS over a span of a couple of years. After a year of working with each LAA to prepare them for the process, BHA began moving SUD ambulatory services to FFS, with all services transferred by January 1, 2017. These services include ambulatory withdrawal management, assessment, Level I Outpatient, Level II.1 Intensive Outpatient, and opioid treatment services. The estimated dollar amount of the transfer is approximately $21.4 million, and will be funded utilizing the Cigarette Restitution funds that BHA receives. Furthermore, in anticipation of the new federal waiver previously mentioned for SUD residential treatment, these services will be transitioned to FFS under the ASO on July 1, 2017. This will now mean that a majority of the treatment dollars in the system for both State-funded and uninsured services will now be financed on a FFS basis. Even after these transfers, about $50.5 million will remain for grants to the LAAs to fund treatment services that are not currently reimbursable by Medicaid or are not included under the State-funded treatment regime for Medicaid-eligible individuals, such as some recovery services as well as peer and family supports. This is in comparison to the almost $67.0 million that the CSAs receive for similar services and programming for individuals with a severe mental illness.

Oversight Entities Still Separate

Now that the specific treatment dollars have been split out from the other grant funding, the last vestige of a separate system remains the local entities that help oversee the Public Behavioral Health System: the CSAs and LAAs and the State funding streams for these entities. While some CSAs and LAAs have combined into a single entity, with the notable example of Baltimore City, the vast majority of these entities are still separate throughout the State. To the extent that these entities still provide some services, they are receiving separate streams of funding to support separate programming for separate individuals. Some coordination has been taking place among the entities, most notably the fact that they have formed a unified association where representatives from each CSA and LAA meet to discuss issues and coordinate efforts. However, as long as there remain separate entities with separate funding streams, this can create a situation where an individual with a co-occurring disorder may have to switch treatment providers or go to separate providers in order to maintain their access to the treatment services that are funded through the grant based system. **DLS is recommending the adoption of committee narrative that requests BHA and DHMH to study the issue of combining LAAs and CSAs into integrated Behavioral Health Authorities and report back to the General Assembly with their recommendations.**

Recommended Actions

1. Adopt the following narrative:

   Combining the Various Behavioral Health Authorities: Given the policy imperative to fully integrate behavioral health services in the State, the Department of Health and Mental Hygiene (DHMH) should provide a report on the feasibility, costs, and benefits of merging the core service agencies (CSA) with the local addictions authorities (LAA). This report should include information on the grants that each recipient entity receives, including how grants are divided up amongst administrative and treatment costs, and how the experience of those counties with merged behavioral health authorities differs from the counties where these authorities remain separate. Finally, the report should include recommendations on whether or not it would be beneficial to the oversight and efficiency of the public behavioral health system to combine the CSA and LAA in each jurisdiction where it is not already so. This report should be submitted by November 1, 2017.

Information Request	**Author**	**Due Date**
Report on combing the CSAs with the LAAs in various jurisdictions	DHMH	November 1, 2017

2. Add the following language to the general fund appropriation:

   Further provided that $2,103,478 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for the purpose, but instead may only be transferred to Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to cover shortfalls in base spending for that program. Funds not expended for this restricted purpose may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund.

   Explanation: This language restricts funding included in the fiscal 2018 budget for 1% of a proposed 2% community provider rate increase, and instead directs that the additional funds may only be transferred to Program M00Q01.10 in order to cover shortfalls in spending based on estimates of significant deficiencies in the budget for that program. This restriction allows for only a 1% rate increase for community providers. Any funds not transferred for this purpose shall revert to the General Fund.

3. Add the following language to the general fund appropriation:

   , provided that $365,024 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for that purpose, but instead may only be transferred to Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to cover shortfalls in base spending for that program. Funds not expended for this restricted