



Maryland
Hospital Association

Maryland Behavioral Health System of Care Design Process: Preliminary Recommendations from the Maryland Hospital Association Medicaid System of Care Task Force

Introduction

The Maryland Hospital Association (MHA) Medicaid System of Care Task Force (MHA Task Force)¹ has served as one of the discussion groups within Maryland Medicaid's Behavioral Health System of Care Design Team since summer 2019. Maryland's hospitals and health systems appreciate being involved in Maryland Medicaid's inclusive and deliberative process to improve the state's behavioral health system.

The MHA Task Force met monthly from July to December 2019. Members suggested ways to address the issues Maryland hospitals experience as they deliver behavioral health care to Medicaid enrollees. This document presents the MHA Task Force's recommendations thus far.

The Pivotal, Multi-dimensional Role of Hospitals in the Behavioral Health System

Hospitals occupy a unique position within the behavioral health care system. They provide several levels of care across the continuum through services that are purpose-built and appropriately placed within hospitals. They also play an important role as safety net providers for individuals, many in crisis, who cannot access appropriate upstream, community, or specialized services elsewhere. In treating the whole person, hospitals also address both their physical and behavioral health conditions. MHA's assessment of 2016 and 2017 Medicaid hospital data² for enrollees with primary and/or secondary behavioral health³ diagnoses found:

- High percentages of co-occurring secondary substance use disorder diagnoses among the five most common somatic primary diagnoses for emergency department visits
- Four of the top five primary diagnoses for readmissions within 30 days were behavioral health-related
- Schizophrenia and alcohol-related disorders were within the top five primary diagnoses for hospital admissions
- Among high utilizers (individuals with three or more behavioral health-related encounters), almost 90,000 unique Medicaid enrollees (representing approximately 8%

¹ See Appendix for list of MHA Task Force members.

² Health Service Cost Review Commission (HSCRC) Inpatient and Outpatient Revisit Files for Calendar Years 2016 and 2017.

³ MHA defined behavioral health services as including both mental health services and substance use disorder services.

of total Medicaid recipients) had three to 10 emergency room visits, and more than 1,600 unique enrollees had 50 or more visits

Recommendations for Improving the Behavioral Health System of Care

MHA Task Force conversations to date focused on holistic improvement of the behavioral health system of care, irrespective of any financing model changes. Thus, the following recommendations—on care coordination, access, and quality—apply to efforts to improve the state’s behavioral health system.

CARE COORDINATION

Integrate service payments for treatment of co-occurring behavioral health diagnoses.

Caring for complex patients with co-occurring mental health and substance use disorders (SUD) is hindered by bifurcated delivery systems and coverage and payment rules. In practice, this bifurcation prohibits providers from billing for mental health and SUD services on the same day. Many patients require simultaneous, coordinated mental health and SUD treatments. Restrictions on same-day billing for these co-occurring conditions make it difficult for providers to optimally care for these individuals. Further, reimbursement policies for mental health or SUD treatment services do not accurately encompass the extent of the care rendered for individuals with co-occurring diagnoses. Restructuring these policies will ensure payments properly match services a patient requires. One example of such a restructure is Maryland’s institutions for mental disease waiver for substance use conditions, which includes structural changes eliminating the need to specify which condition is primary on an inpatient admission.

Strengthen case management coordination to improve patient transitions between different levels of care and between components of the behavioral health system (ASO, MCO, and LBHA).

The delegation of responsibility for case management and care coordination duties within the public behavioral health system is unclear. The administrative services organization (ASO), managed care organizations (MCOs), and local behavioral health authorities (LBHAs) do not share a common understanding of the definition of those activities, their responsibilities to work together to perform them, or their own and others’ management and coordination responsibilities. Specifically, there is uncertainty and geographic variability regarding the ASO, MCO, and LBHA roles in both preadmission and discharge planning; with the latter, particularly when a patient returns to their community and requires specialty behavioral health care. Similar concerns have been noted in the Maryland Department of Health’s Post-Acute Care Discharge Planning Workgroup Report, which was released in fall 2019 and recommends ways to improve the discharge process for complex and high-utilizer patients.

Without a strong identified lead for case management after discharge, patients often lose their way navigating through transitions in care, resulting in increased likelihood of hospital

readmission. Guidance to these entities should also include well-delineated duties of the ASO and MCOs, to promote seamless coordination throughout the state’s behavioral health system and ensure there is truly “no wrong door” for Medicaid enrollees.

Adopt appropriate, recognized level of care assessment tools to ensure patients can enter and stay at the level of care appropriate for their needs.

The state should adopt standard, evidence-based, reliable and clinically-appropriate level of care assessment tools to guide determinations of the level of need and the types and levels of facility-specific care available to fulfill the need. Currently, the ASO, MCOs, providers and behavioral health organizations use disparate protocols to identify the level of care a patient requires. Having all assessors and payers use a common set of assessment tools will ensure that patients are more accurately and uniformly evaluated.

ACCESS

Use accepted, nationally recognized clinical standards for coverage policies and utilization management practices.

Coverage policies, such as limiting observation services payment to 23 hours, hinder the ability to deliver care in the most appropriate setting. Until 2017, Medicaid covered observation services on par with Medicare policies: payment for observation care for up to 48 hours, extending up to 72 hours if medically necessary. This departure from the Medicare standard makes it difficult for Maryland hospitals to properly stabilize Medicaid patients experiencing acute behavioral health episodes in outpatient care. Needless inpatient admissions can be avoided, and patients could be safely discharged to home if given additional time under observation status.

Hospitals urge the state to conduct more oversight and ensure the clinical coverage and utilization management policies the ASO and MCOs are implementing appropriately approve necessary services for Medicaid patients. We recommend utilizing nationally recognized clinical guidelines to establish medical necessity criteria that reflect generally accepted standards of care, such as those promulgated by the American Society of Addiction Medicine.

Invest in capacity for appropriate, high-quality preventive and continuing care services so patients receive treatment at the right level of care, preventing crises and unnecessary use of hospital services.

The Maryland Department of Health’s 2019 Statewide Review of Behavioral Health Workforce and Capacity Joint Chairman’s Report—focused on the public behavioral health system—revealed service gaps in support and community-based services for individuals and families

affected by mental health, SUD, and co-occurring conditions. Moreover, the report identifies a continuing shortage of mental health and SUD professionals in both rural and metropolitan areas.

When patients cannot access behavioral health services in their community due to workforce gaps, they turn to hospitals as safety nets to get help for issues that could have been effectively managed at a lower level of care. Even if hospitalization is the appropriate level of care at the time, hospitals have difficulty discharging patients due to a lack of appropriate community behavioral health providers to which they can be safely released for follow-up.

Compounding the behavioral health workforce shortage is the fact that many behavioral health providers in Maryland do not accept Medicaid. This is most often due to low Medicaid fees. The result is “phantom benefits” for the Medicaid population: while services may be covered under the Medicaid benefit, no providers exist to deliver them. Higher payment rates—perhaps tied to quality, as noted below—will yield a more robust, high-value provider network. In addition, network adequacy metrics should be developed to ensure robust access on a continuing basis.

QUALITY

Move beyond the “any willing provider” (AWP) standard to require more quality checks of providers. Apply more stringent entry criteria and monitor quality performance for ongoing participation.

Although the AWP standard maximizes the number of providers that may come into the public behavioral health system, it does not necessarily produce better patient outcomes.

Currently, Medicaid only requires initial provider licensure or accreditation to participate in the program. These basic barriers to entry do not address the equally important components of continued integrity and performance. To ensure provider quality, ongoing program compliance monitoring should be enacted, over time, using process and outcome measures.

Additionally, accountability for bad actors and low-quality providers should be enforced in a timely manner.

Quality measurement should be phased in, beginning with identification of data sources and data collection to set appropriate benchmarks. Later, quality should be reflected in value-based provider payments and program participation. Before factoring quality into payment, the state should identify providers who need help improving quality and make assistance available. This approach ensures that moving away from the AWP standard will not lessen access to good care; it ought to improve quality of all behavioral health care for Medicaid enrollees.

Phase in policies that require behavioral health providers to apply evidence-based treatment approaches in areas where broad consensus has developed. Support community-based providers in building the capacity to render such treatment.

Hospitals understand that opportunities to apply evidence-based treatment approaches in the behavioral health arena might be somewhat limited at present. But there are areas where a broad consensus has emerged on the most effective therapies; for example, the use of medication assisted therapy (MAT) as part of treatment of opioid use disorder. To further stem the opioid crisis, Maryland policy should be that the use of MAT is not just a matter of provider preference. As evidence builds for other treatments, the same policy should apply.

Be flexible in determining quality metrics and monitoring program compliance.

Quality metrics should be tailored closely to the types of conditions treated by each behavioral health provider. Uniform measurements beyond standard health care utilization metrics (*e.g.*, emergency department visits; admissions; medication adherence) do not account for the vast array of conditions treated by behavioral health providers. One way to allow for flexibility in measurement could be to create a list of acceptable measures from which providers may select a subset that is most meaningful for the patients they treat.

Compliance monitoring also should flex where suitable. Providers who perform well under any value-based program developed by the state should not be the focus of rigorous monitoring. Those performing below thresholds set by the state should be more actively audited.

Conclusion

The MHA Task Force endorses Maryland Medicaid's Behavioral Health System of Care design process and appreciates the opportunity to work with the state on this momentous endeavor. Hospitals are confident that the state's deliberate approach will improve care for Marylanders with behavioral health conditions.

Appendix: MHA Medicaid System of Care Task Force Members

Dr. Harsh Trivedi, President & CEO, Sheppard Pratt Health System (Co-Chair)

Eric Wagner, Executive Vice President, Insurance and Diversified Options, MedStar Health (Co-Chair)

Dr. Stephen Band, Director of Psychology and Neuropsychology, Mount Washington Pediatric Hospital

Patrick Dooley, Vice President, Population Health, University of Maryland Medical System

Kathryn Fiddler, Vice President, Population Health, Peninsula Regional Health System

Nicole McCann, Vice President, Provider/Payer Transformation, Johns Hopkins Health System

Dr. Matthew Poffenroth, Chief Clinical Officer/Dawn Hurley, Associate Vice President, Behavioral Health, LifeBridge Health

Maansi Raswant, Vice President, Policy, Maryland Hospital Association

Marcel Wright, Vice President, Behavioral Health Services, Adventist HealthCare