

# Behavioral Health System of Care Design Component Quality Principles Development Document

## **Preamble**

Goal: To better serve Medicaid participants by developing a System of Care that addresses the needs of individuals by aligning the roles of Medicaid/the Behavioral Health Administration, the managed care organizations (MCOs), the administrative service organization (ASO), and local systems management.

## ***Quality Integrated Care Management***

### Person-/Family-Focused

- The system should engage participants in the treatment and recovery process.
- The system should be simple and flexible enough for participants and families to understand and navigate.

### Quality/Effectiveness of Care

- The system should be designed with a chronic disease management foundation coupled with early detection and intervention. It further uses a recovery model that includes stages of change and levels of care where complexity is the rule, not the exception.
- Quantitative and qualitative person-centered outcome measurement should determine if people are getting better. Use evidence-based treatment and promising practices where evidence exists.
- The system should have strong case management, person-centered treatment planning, data collection, and transition planning processes that align ASO, MCO, provider, and local system management efforts.
- The system should integrate physical and behavioral health provider plans of care. Follow up should include outreach, case review, and regular communications with local systems managers.
- Within behavioral health, mental health and substance use disorder treatment should be integrated.
- The system should assure seamless integration with non-Medicaid behavioral health services for Medicaid participants.

### Data Sharing and Clinical Outcomes/Process Measurement

- Data flows between the ASO and MCOs should be optimized to improve care coordination and participant information sharing, while maintaining legally required participant confidentiality standards, including current 42 CFR Part 2 regulations.
- All providers should have access to read-only, real-time, easily interpretable, and actionable ASO data, and behavioral health providers should have the ability to feed electronic health record (EHR) data into the system.

## ***Oversight and Accountability***

- To the greatest extent possible, individuals should not experience disruption in their clinical treatment as their payer status changes.
- Ensure that there is accountability for providing participants with navigation assistance as they move through the continuum of coverage, which includes transitions in and out of Medicaid, Medicare (both duals and those turning 65), and uninsured spans.
- The system should have clearly-defined responsibilities across the various regulatory and accrediting authorities.
- System design should facilitate cross-agency coordination, including state agencies, the ASO, MCOs, and local systems managers, to ensure that timely care coordination occurs as individuals move across systems.

## ***Cost Management***

- The system should have shared deliverables for health outcomes from the ASO, MCOs, and local systems managers, and all parties should be held accountable for their performance.
- The system should lower costs in the Total Cost of Care Model through reduction of waste and inefficiency, improved treatment effectiveness, better coordination of physical and behavioral health, and adequate availability of community alternatives to hospitalizations.
- The system should manage high utilizers within a chronic disease management framework.
- The system should provide shared financial and other incentives to promote positive clinical outcomes.
- System design and contract terms should incentivize communication among providers and payers to ensure optimal use of funds.
- The system should prevent cost-shifting to other state agencies.
- The system should attempt to align with Centers for Medicare & Medicaid Services (CMS) innovations.

## ***Access to Behavioral Health Services through Provider Administration and Network Adequacy***

- The system should minimize duplicative overhead burden for providers.
- Authorization decisions must be timely.
- Providers in the system should be measured by clinical outcomes.
- The system should account for the right mix of providers to include provider types and geographic distribution.

- The system must work for both programs (facilities) and independently practicing clinicians.
- The system must provide for fair, impartial, and timely internal and external grievance and appeals processes.
- People should be treated in the most appropriate and least restrictive environment possible.
- Behavioral health resources management should be comparable to somatic management practices and implemented through strong qualified provider standards that are supported by efficient oversight and compliance mechanisms or a rating system.

### ***Parity***

- Maryland's public behavioral health system must comply with federal and state parity laws, and oversight measures must be implemented to track compliance.
- Treatment of behavioral health should have equal priority with physical health care.

## **Definitions of Key Terms**

Care Coordination - Care coordination involves optimally organizing participant care and information-sharing activities. This means that the participant's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the participant (Agency for Healthcare Research and Quality, <https://www.ahrq.gov/topics/care-coordination.html>).

Case Management - Assessing, planning, coordinating, monitoring, and arranging the delivery of medically necessary, health-related services (COMAR 10.09.62.01(B)(23)).

Case Management Lifecycle – Refers to case management across a participant’s lifespan.

Chronic Disease - A condition or conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both and for which there is no cure. (<https://www.cdc.gov/chronicdisease/about/index.htm>).

Chronic Disease Management Model - An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and participant education. It can improve participant quality of life while reducing health care costs by preventing or minimizing the effects of a disease (<https://www.healthcare.gov/glossary/chronic-disease-management/>).

Clinical Outcome Measures – Measures that reflect the impact of the health care service or intervention on the health status of participants (Agency for Healthcare Research and Quality <https://www.ahrq.gov/talkingquality/measures/types.html>).

Continuum of Care - An integrated system of care that guides and tracks an individual over time through a comprehensive array of health services spanning all levels of intensity of care (NIMH, <https://www.ncbi.nlm.nih.gov/pubmed/10293297>).

Culturally and Linguistically Appropriate - Effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs (HHS Office of Minority Health, <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>).

Discharge Planning - A process that involves determining the appropriate post-hospital discharge destination for a participant; identifying what the participant requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the participant’s identified post-discharge needs (Centers for Medicare and Medicaid Services [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf) ).

Early Detection and Intervention- Addresses a behavioral health condition early in its manifestation, is relatively low intensity, is of relatively short duration, has the goal of supporting wellbeing in major life domains and avoiding the need for more extensive behavioral health services, and may include individual screening for confirmation of potential behavioral health needs (<https://www.rcdmh.org/MHSA/pei>).

Evidence-Based Treatment - Refers to a set of standardized, replicable interventions for which rigorous scientific research exists to demonstrate the effectiveness of the interventions, when implemented as designed, in achieving meaningful, positive outcomes for individuals who have

received the interventions. Fidelity Assessments and evaluations are systematically performed to determine adherence to established Evidence Based Practice standards (Mona Figeroa, BHA Director of Evidence Based Practices).

Family-Focused - Recognizes the important role of family members and caregivers in the design and implementation of services (SAMHSA, <https://www.samhsa.gov/section-223/care-coordination/person-family-centered>).

High Utilizers - Also known as high cost users. A group of persons who account for a disproportionately large share of all medical charges (NIH, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192887/>).

Integration - The care that results from a practice team of primary care and behavioral health clinicians, working together with participants and families, using a systematic and cost-effective approach to provide person-centered care for a defined population (Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: <http://integrationacademy.ahrq.gov/lexicon>).

Least Restrictive Environment Possible - Treatment and services which will best meet the participant's treatment and security needs and which least limit the participant's freedom of choice and mobility (<https://www.dhs.wisconsin.gov/clientrights/cgdd-least-restrictive.pdf>).

Local Systems Manager - The Core Service Agencies (CSAs), Local Addictions Authorities (LAAs), and Local Behavioral Health Authorities (LBHA) who are responsible for planning, developing, and managing a full range of treatment and rehabilitation services for persons with serious mental illness and substance use disorder in their jurisdictions. These agencies collaborate with other human service agencies to promote comprehensive services for individuals with mental illness and substance use disorder who have multiple human needs (Maryland Association of Behavioral Health Authorities, <https://www.marylandbehavioralhealth.org/>).

Parity – Refers to the implementation of the Mental Health Parity and Addiction Equity Act that requires the provision of mental health and substance use disorder treatment and services at the same level as medical and surgical care. Financial requirements and quantitative treatment limitations for mental health and substance use disorder treatment may be no more restrictive than the predominant requirements for substantially all medical/surgical benefits. Non-quantitative treatment limitations must be comparable to and applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits (45 CFR§146.136;(c)). Federal regulations apply parity requirements to Medicaid MCOs and the Medicaid expansion population. All Medicaid beneficiaries who receive services through an MCO must be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the MCO or another service delivery. States must include contract provisions requiring compliance with parity standards in all applicable contracts with Medicaid MCOs and, in states in which mental health and substance use disorder services are delivered through an entity other than an MCO, the state is responsible for evaluating parity compliance and submitting compliance reports to the Centers for Medicare and Medicaid Services and posting reports for the public. (Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008,

81 Fed. Reg. No. 61, 18,390 (March 30, 2016) (to be codified at 42 CFR Parts 133 438, 440, 456, and 457). Available at <https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf>.)

Person-Centered - Individuals have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual (SAMHSA, <https://www.samhsa.gov/section-223/care-coordination/person-family-centered>).

Person First Language - Eliminates generalizations, assumptions and stereotypes by focusing on the person rather than their disability. As the term implies, person first language refers to the individual first and their disability second (Texas Council for Developmental Disabilities, <https://tcdd.texas.gov/resources/people-first-language/>).

Physical Health – Within the context of parity, refers to medical/surgical benefits, which are items or services or medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines). Medical/surgical benefits include long term care services (42 CFR §438.900).

Primary Behavioral Health - Medically necessary primary behavioral health services are provided by primary care providers and are paid for by MCOs (COMAR 10.09.65.14).

Primary Care Setting – Refers to medical care that addresses a participant’s general health needs, including the coordination of the participant’s health care, with the responsibility for the prevention of disease, promotion and maintenance of health, treatment of illness, maintenance of the participant’s health records, and referral for medically necessary specialty care (COMAR 10.67.01.01(B)(140)).

Program - A system of activities performed for the benefit of persons served (CARF, 2019 Behavioral Health Standards Manual).

Promising Practices - Programs and strategies that have some scientific research or data showing positive outcomes in delaying an untoward outcome, but do not have enough evidence to support generalizable conclusions (HHS-NIH, Using What Works).

Provider (Organization or Individual) - means an individual, association, partnership, corporation, unincorporated group, or any other person authorized, licensed, or certified to provide health services (COMAR, 10.09.33.01).

Recovery - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, <https://store.samhsa.gov/system/files/pep12-recdef.pdf>).

Serious Mental Illness - A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI (NIMH, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>).

Specialty Behavioral Health - Any behavioral health service other than primary behavioral health services (COMAR 10.09.60.01(B)(166)).

Specialty Care Setting – Refers to health care services that are either outside the primary care provider’s scope of practice or, in the judgment of the primary care provider, are not services that the primary care provider customarily provides, is specifically trained for, or is experienced in (COMAR 10.67.01.01(B)(167)).

Substance Use Disorder - When the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMHSA, <https://www.samhsa.gov/find-help/disorders>)(Diagnostic and Statistical Manual of Mental Disorders (5th ed.), American Psychiatric Association, 2013).

Trauma-Informed - An understanding of trauma and an awareness of the impact it can have across settings, services, and populations as well as recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic (SAMHSA, <https://store.samhsa.gov/system/files/sma15-4420.pdf>).

Timely - The health care system's ability to provide health care quickly after a need is recognized. A delay in the time between identifying a need for a specific test or treatment and actually receiving those services can negatively impact health and costs of care (<https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>).

Total Cost of Care Model - Refers to the 10-year agreement between the State of Maryland and the Centers for Medicare & Medicaid Services governing Maryland’s all-payer hospital system. For more information, see <https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf>.

Uninsured – A person who does not have minimum essential health insurance coverage, which includes government-sponsored coverage, employer-sponsored coverage, coverage through the individual market, or other coverage recognized by the U.S. Department of Health and Human Services and the Internal Revenue Service (26 USC §5000A(f)).

Wellness - Being healthy in many dimensions of our lives. That includes the emotional, physical, occupational, intellectual, financial, social, environmental, and spiritual parts. These dimensions are interconnected, one dimension building on another (SAMHSA, <https://store.samhsa.gov/system/files/sma16-4958.pdf>).