Maryland's Care Management Model in Relation to Health Care Reform and Behavioral Health Integration Efforts

2012-2014: Years of Health Care Transition in Maryland

In the December 2011 report commissioned by the Department of Health and Mental Hygiene (DHMH) and submitted to the General Assembly entitled, *Future Options for Integrated Behavioral Healthcare*, Secretary Sharfstein sets forth seven principles that will guide DHMH's behavioral health integration. The seventh principle is one that resonates in particular with the Children's Cabinet and the Maryland Care Management Model: *A new system should be able to coordinate well with other systems, including the criminal justice, education, and child welfare systems, to promote social outcomes such as successful community reintegration, adoptions and permanent placements, school achievement, and others.*

Efforts in Maryland both to implement the Patient Protection and Affordable Care Act (aka Health Care Reform) and integrate behavioral health services have recognized the unique needs of children with intensive, multi-system requirements. Nationally, experts agree on the need to coordinate physical and behavioral health care for children and that every child should have a designated medical home. However, the integration of financing for physical and behavioral health care for all populations, without specialty service delivery design for behavioral health care for children, has shown to lead to child behavioral health funding being absorbed by physical health issues, primarily for adults. Children with serious behavioral health disorders do not have the same high co-morbid chronic medical conditions as the adult population. Instead, these populations of children have many more needs for coordination with social services, the courts and education. Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families.

As highlighted in the consultant report, Maryland's Care Management Entity (CME) Model is an example of a specialty provider-based model for youth with serious behavioral challenges that coordinates care and funding across behavioral health, child welfare, juvenile services and education. **At this moment in Maryland, there three equally pressing needs related to CMEs: 1) a need to ensure alignment and inclusion of the CME Model within DHMH behavioral integration efforts and overall health care reform as articulated in the above seventh guiding principle; 2) a need for continuity of service delivery for populations currently served through by the current Governor's Office for Children CME contract on behalf of the Children's Cabinet; and 3) a need to design and implement a 1915(i) Home and Community Based Services State Plan Amendment (SPA) for the RTC Waiver population.** While there may be frustration with the need for both the 1915(i) SPA and the recently released CME RFP issued by the Governor's Office for Children (GOC) on behalf of the Children's Cabinet, both the GOC CME RFP and the 1915(i) SPA serve certain purposes and each has its own limitations.

The 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Medicaid Demonstration Waiver (aka RTC Waiver) was not authorized by Congress beyond September 30, 2012. DHMH reviewed all relevant options and received technical support from the Center for Medicare & Medicaid Services (CMS) to identify Medicaid opportunities for continuity of care for youth who meet Community-Based RTC Level of Care. Under the Affordable Care Act, changes were made to the 1915(i) requirements that made it a more viable option for Maryland to pursue and, as such, it became the best option available.

Why can't the GOC CME RFP include the 1915(i) population of youth?

The GOC CME RFP does *not* include the population of youth expected to be served under the 1915(i) SPA because care coordination will be a service provided by the CME under this specialty system, which will be administered by DHMH. As part of the sustainability model for the CMEs under the 1915(i) SPA, DHMH is intending to ensure that CMEs are Targeted Case Management (TCM; aka Mental Health Case Management) providers that are authorized by the Core Service Agencies. This will assist with the alignment of the 1915(i) with health care reform and integrate it into the larger PMHS.

Why do you need the GOC CME RFP—can't you just use the 1915(i)?
The GOC CME RFP is needed to serve youth who are not eligible for the 1915(i) SPA, including juvenile services and child welfare group home diversion, the System of Care Grant populations (MD CARES & Rural CARES), and the youth who are unable to be enroll in the 1915(i) SPA at the conclusion of the PRTF Demonstration Grant (including youth who are financially eligible for the RTC Waiver only because of their family of one Medical Assistance eligibility). The 1915(i) SPA can only serve youth who are community-Medicaid eligible and who meet the medical eligibility criteria.

While both the 1915(i) and the GOC CME RFP will fill vital gaps in service delivery, both have significant restrictions. However, as was the case with the first Statewide CME contract**, both the GOC CME RFP process and the 1915(i) are transitional steps that must be taken as we move towards health care reform and DHMH behavioral health integration in 2014**. Unfortunately, health care reform has yet to evolve enough to keep the pace with the strides Maryland has made in the development of our CME Model. Over the next two years we need to use the "tools" available in our "toolbox" and work together to preserve the CME Model so that it will be a viable "tool" throughout this phase of the State's behavioral health integration and health care reform efforts that will culminate in 2014 when remaining provisions in the Affordable Care Act become effective.

The CME Model can ensure that the unique needs of children with serious behavioral health needs are met as they provide an ideal platform to serve as a specialized or designated provider of a health home. CMEs meet the standards for Section 2703 of the Affordable Care Act for health home providers and have demonstrated expertise and capacity to coordinate care with primary care as well as other systems essential to supporting positive outcomes for children. In the absence of health homes, CMEs can be embedded as part of the larger managed behavioral health delivery system as specialty providers for high-need children.

Most importantly, through behavioral health integration and health reform, CMEs can be financed through blended sources of funding to cover both the populations included in the GOC CME RFP and 1915(i), as well as additional identified populations. Further, there is room for evolution in Maryland's contracting and financing models, which may include the implementation of case rates (risk-based and non-risk based) that allow for greater flexibility of service provision in exchange for risk and outcome based contracting.

Local Care Teams – Another "Tool" in Maryland's "Toolbox"
During the 2011 legislative session, in accordance with the Maryland Child and Family Services Interagency Strategic Plan (ISP), the Children's Cabinet proposed changes to the legislation governing the State Coordinating Council and the Local Coordinating Councils as recommended by the workgroup formed to address the ISP Interagency Structures recommendations. House Bill 840 provisions went into effect on July 1, 2011. HB 840 was enacted to establish Local Care Teams (LCTs) to:

1. Be a forum for:
    a. Families of children with intensive needs to receive assistance with the identification of individual needs and potential resources to meet identified needs;
    b. Interagency discussion and problem solving for individual child, family, and systemic needs;
2. Refer children and families to:
    a. CMEs when appropriate; and
    b. Available local and community resources;
3. Provide training and technical assistance to local agency and community partners;
4. Identify and share resource development needs and communicate with the CME, local Core Service Agency, provider networks, Local Management Boards, and LCTs in surrounding jurisdictions; and
5. Discuss a request for a voluntary placement agreement for a child with a developmental disability or a mental illness under § 5-525 of the Family Law Article.

LCTs can be maximized at the local level to help coordinate referral and access between the CMEs selected for both 1915(i) and the GOC CME RFP.