

Senate Bill 58

Behavioral Health Integration

Advisory Committee

Second Report to the
Health and Human Services Commission

July 8, 2015

Table of Contents

Legend of Acronyms	3
I. Executive Summary.....	4
II. Committee Process	5
III. Recommendations.....	7
a. Holistic Treatment.....	7
b. Member Activation	9
c. Access to Behavioral Health Services.....	10
d. Administrative Simplification.....	11
e. Payment Mechanisms.....	12
f. Outcome Measurement.....	13
g. State Oversight.....	15
h. Health Home Pilots	16
IV. Next Steps	18
V. Appendix A. List of Committee Members.....	19
VI. Appendix B. BHIAC Phase I and Phase II Final Recommendations.....	21
VII. Appendix C. HHSC Actions to Date on Phase I Recommendations.....	25
VIII. Appendix D. Draft Recommendations Referred to Other Entities	32

Legend of Acronyms

Acronym	Full Meaning
BHIAC	Behavioral Health Integration Advisory Committee
BHO	Behavioral Health Organization
DSHS	Department of State Health Services
HHSC	Health and Human Services Commission
HIE	Health Information Exchanges
HIPPA	Health Insurance Portability and Accountability Act
HPM	Health Plan Management
MCO(s)	Managed Care Organizations
PMPM	Per Member Per Month
SAMHSA	Substance Abuse and Mental Health Services Administration
UMCC	Medicaid Uniform Managed Care Contract
UMCM	Medicaid Uniform Managed Care Manual

I. Executive Summary

The Senate Bill 58 Behavioral Health Integration Advisory Committee (BHIAC) acknowledges the importance of integrating health care to achieve optimal health outcomes and recovery for Medicaid members. Integrating the Medicaid covered benefits into one system is only one step in a series that is required in order to move the Medicaid system forward in providing holistic care. A truly integrated system for Medicaid members fosters recovery, ensures parity and achieves the triple aim of improving the quality of care, controlling costs, and improving a Medicaid member's experience.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

The BHIAC recommends a focus on eight areas to facilitate transparency and accountability in a complex system:

- **Holistic Treatment.** Holistic care is an approach to health and wellness that includes treatment for all conditions in a coordinated fashion. Integrating mental health, substance use, and primary care services produces the best outcomes and proves the most effective approach to caring for Medicaid members with multiple healthcare needs.
- **Member Activation.** Members play a vital role in their health and wellness and must have the knowledge, skills, and confidence to manage their health. The Medicaid system plays an important role in providing opportunities for members to become actively engaged participants in their health care.
- **Access.** Medicaid members must have access to a continuum of quality health care to improve health outcomes.
- **Administrative Simplification.** In a multi-payer managed care system, efforts must be made to simplify the administrative burden for providers in order to maximize their efficiency and time with members.
- **Payment Mechanisms.** Traditional provider payment mechanisms do not support integrated care. New payment structures are required to incentivize and support care of members with complex health conditions including support of person-centered care, care coordination and provider-to-provider communication.
- **Outcome Measurement.** Measuring health outcomes are integral to assessing the quality of care; and are extremely useful in quality improvement, public reporting, and incentive programs.
- **State Oversight.** The Health and Human Services Commission (HHSC) plays an important role in oversight of the managed care system. State actions should encourage an efficient and effective system.
- **Health Home Pilots.** Health homes are a critical component in the integration of health care for Medicaid members with mental illness and other chronic health conditions.

Using these areas, the Committee adopted a specific set of recommendations for each area to transform the current Medicaid program to meet the goals of integration. Some of these recommendations were made in June 2014, others in June 2015. For those recommendations from June 2014, HHSC has implemented a subset of the recommendations. For a status of adoption and implementation of the June 2014 recommendations, please see Appendix C.

Timely action and a transparent reporting process are important as HHSC moves forward towards a more integrated approach to healthcare. BHIAC members are concerned that the elimination of the advisory committee will impede the transformation of the system. This report recommends high-level policy changes but many decisions must be made as operational procedures are written. Without the BHIAC, or another committee with similar membership, HHSC will not have a stakeholder voice in the process of implementation. The BHIAC can provide continuity of feedback to HHSC from high-level policy to operational procedures if it is not eliminated.

II. Committee Process

Senate Bill 58 of the 83rd Texas Legislature (Regular Session) required the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) to establish a Behavioral Health Integration Advisory Committee (BHIAC). The BHIAC is charged with providing HHSC with formal recommendations addressing the planning and development needs of integrating Medicaid behavioral health services, including targeted case management, mental health rehabilitative services and physical health services into Medicaid managed care, by September 1, 2014. In addition, the committee must seek input from the behavioral health community.

The Behavioral Health Integration Advisory Committee consists of members representing the following categories:

- Individuals with behavioral health conditions who are current or former recipients of publicly funded behavioral health services or family members of individuals living with a mental illness.
- Representatives of managed care organizations that have expertise in offering behavioral health services.
- Public and private providers of behavioral health services.
- Providers of behavioral health services who are both Medicaid primary care providers and providers for individuals who are dually eligible for Medicaid and Medicare.

The Behavioral Health Integration Advisory Committee was established by December 1, 2013 with the first public meeting occurring on December 11, 2013. The committee set two phases to its work based on topics that needed to be addressed immediately for the contract changes occurring on September 1, 2014, and longer-term topics that could be addressed after the September 1, 2014, implementation. Due to the complex nature of discussing quality measures, the discussion was included in both Phase I and Phase II but all discussions and recommendations on quality measures are published in the BHIAC's final report.

Phase I Topics

Phase II Topics

Managed Care Organization Contracts	Integration of Behavioral and Physical Health Services
Stakeholder Communication	Health Home Pilots
Quality Measures	Quality Measures
HHSC Coordination and Oversight	

The Committee solicited public input in the following Phase I recommendation areas: Managed Care Organization Contracts, Stakeholder Communications, HHSC Coordination and Oversight, and Quality Measures. The Phase II recommendation process covered: Integration of Behavioral Health and Physical Health Services, Health Home pilots and Quality Measures.

For both phases, a public recommendations form was posted on the advisory committee's website for the public to provide their recommendations. The committee received over 530 draft potential recommendations from the members and the public. The committee held seven meetings and discussed every potential recommendation over the course of 2014 and 2015.

The Committee completed its Phase I recommendations in June 2014, presented the Phase I recommendations to the Executive Commissioner of HHSC in August 2014, and then continued to meet to further consider issues related to integration, quality measures, and health homes. The final report presented here includes recommendations from Phase I and Phase II of the BHIAC work.

The Committee did not address specific recommendations on the Utilization Management process for specialty behavioral health services carved into managed care under SB58. When the BHIAC began its process, HHSC intended to form a separate workgroup to consider recommendations related to utilization management processes, with a potential implementation date for changes of September 1, 2015. During the course of BHIAC meetings, HHSC changed its strategy for soliciting stakeholder feedback and decision making related to the utilization management process for SB58. HHSC held the first meeting on this topic on June 12, 2015, and is starting a Medicaid Benefit Design review process in the summer of 2015.

III. Recommendations

The Senate Bill 58 Behavioral Health Integration Advisory Committee acknowledges the importance of integrating health care to achieve optimal health outcomes for Medicaid members. The Committee recognizes that a holistic approach to person-centered care and wellness promotes recovery and embraces a comprehensive philosophy of healing mind, body and spirit. A cornerstone of recovery is hope and the desire to live a full life, which directly impacts the effectiveness of treatment for physical and mental health conditions.

Integrating Medicaid covered benefits into one system is only one step in a series that is required in order to move the Medicaid system forward in providing holistic care for Medicaid members. Transformation of the system is required to better address the needs of Medicaid members with mental illness and other chronic health conditions. The Committee adopted the following recommendations, in eight core areas, for creating the path to transformation.

a. Holistic Treatment

A person's physical health and behavioral health (mental health and/or substance use) conditions do not exist in isolation from one another, and the existence of multiple conditions impact health outcomes and costs throughout the healthcare system. Integration of physical and behavioral health care has the potential to improve the quality of care, control costs and improve the member's experience in receiving care.

Holistic care is an approach to health and wellness that includes treatment for all conditions in a coordinated fashion. Integrating mental health, substance use, primary care and other medical services produces the best outcomes and proves the most effective approach to caring for Medicaid members with multiple healthcare needs. In concept, integrated care means a person with mental illness and/or a substance use disorder, along with other physical health conditions such as diabetes or high blood pressure, will receive holistic care from health care providers that work together to treat all conditions concurrently. Through holistic treatment, there are expanded opportunities for entry into systems of care. The type of provider system first encountered is no longer a barrier to appropriate treatment rather it opens the door to address all health care issues; in essence, a "no wrong door" philosophy.

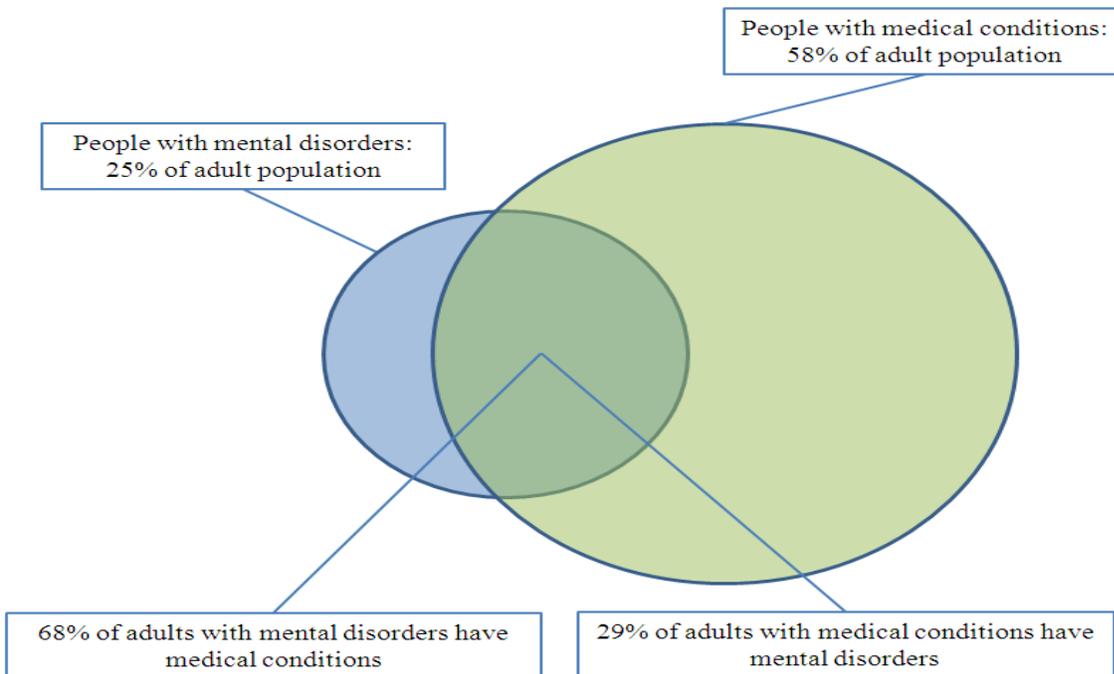
The workgroup recommends a strong focus on holistic care at all levels of the system: state policy, managed care organizations, provider services and member experience. Without aligned systems, the promise of treating the whole person falls short and the opportunity to minimize waste and maximize financial investment without compromising health outcomes is lost. These recommendations are critical to moving the system forward to a more holistic approach to treatment, health and wellness.

Recommendations for Holistic Treatment

1. All Managed Care Organizations (MCOs) must have integrated technology systems and care coordination systems for physical and behavioral health, even when the MCO subcontracts for behavioral health services.
2. Technology should be leveraged to allow all providers and MCOs to have electronic access to a member's full medical record without compromising confidentiality.
3. Care transitions from inpatient to outpatient and from outpatient to inpatient settings must be well coordinated. MCOs must emphasize coordinated discharge planning. HHSC should provide focused attention and oversight on the contract requirements related to discharge planning.
4. HHSC should use the term "Medicaid member" rather than "consumer" in written materials and oral presentations when discussing Medicaid beneficiaries regardless of their health condition or diagnosis.

Why is holistic care a critical element for Medicaid members with mental health conditions?

Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness. Data shows, on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders.



National Comorbidity Survey Replication, 2001-2003

Mental health problems exacerbate physical health issues. Moreover, people with co-occurring conditions tend to utilize higher intensity medical services at greater cost to the healthcare system. The chronic physical health conditions that often affect people with mental illness may be significantly influenced by the side effects of psychotropic medications, which are associated with obesity, elevated cholesterol and high blood pressure.

Eighty seven percent (87%) of years of life lost are due to medical illnesses –especially infectious, pulmonary and cardiovascular diseases and diabetes. In addition, symptoms associated with mental illness can make following the treatment regime for the physical illness difficult. For example, non-adherence rate for medical treatment is three times higher for depressed individuals than non-depressed individuals. The results of multiple chronic conditions are well documented; people with serious mental illness die twenty-five (25) years younger than the average person.¹

b. Member Activation

Medicaid members play a vital role in their health and wellness and must have the knowledge, skills, and confidence to manage their health. Customers of health care are one of the least utilized resources in the delivery of health care in the United States. The health systems in our country have not been developed on a customer model but that is where many strategies for improving health are headed. Customers, and their family and support systems, must be educated and engaged in decision making to improve the health care system. Healthcare professionals are not in the room when many of us make every day decisions that impact our health: Is it time to take my medications? What will I eat for breakfast? Should I go to bed early tonight? What are symptoms I should worry about?

The Medicaid system plays an important role in providing opportunities for members to become active engaged participants in their health care. The committee recommends that HHSC, managed care organizations, providers and members work together to increase information and knowledge of self-care.

Recommendations for Member Activation

1. Medicaid members must receive clear and linguistically appropriate information on their options in selecting a managed care plan and a provider, along with accurate information on which in-network providers are accepting new members.
2. Medicaid members should have easy access to understandable information on physical and behavioral health conditions, and how to maintain health and wellness. This should include innovative technology solutions for accessing individual health records and opportunities for self-care.
3. MCOs should encourage and provide support for enhanced communication with the member and, when appropriate, the member's family.

¹ Parks, J., et al. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

4. Information provided to Medicaid members should include contact information for the HHSC Ombudsman as a point of contact for questions, concerns or complaints.
5. Program or health plan changes should be clearly conveyed to members, advocacy groups and providers. MCOs should be encouraged to include members, advocacy groups and providers on their board or advisory groups.
6. Medicaid members should be encouraged and incentivized to seek help to improve their overall health.

Why is member activation a critical element for Medicaid members with mental health conditions?

Research shows that more activated members have better health outcomes and better care experiences than members who are less activated and that activation can be increased over time. This has been shown with medically indigent patients, different racial and ethnic groups, and patients with multiple chronic conditions. Increasing the Medicaid member's, and the family's, ability to actively participate in their health and treatment can improve outcomes of care.²

c. Access to Behavioral Health Services

Access to a full range of covered services is important for Medicaid members with mental illness and/or substance use disorders. With the integration of specialized mental health services, known as Medicaid mental health rehabilitation and targeted case management services, it is critical that Medicaid members have access to the services and be given a choice in providers.

Medicaid mental health rehabilitation and targeted case management services provide alternatives to higher, more expensive levels of care such as the emergency department and inpatient hospital settings. The services must be available and provided at the time they are needed. Managed care organizations must be prohibited from creating policies that make accessing these services more difficult than in the current Medicaid model.

In addition to Medicaid mental health rehabilitation and targeted case management, MCOs have the flexibility in benefit design to authorize and pay for a full continuum of care in lieu of more expensive inpatient hospitalization or emergency department visits. MCOs can play a key role in building out a continuum of care to provide alternatives to hospitalizations such as peer services, crisis respite, crisis observation, crisis residential, intensive outpatient care and partial hospitalization programs.

Recommendations for Access to Behavioral Health Services

1. MCOs should be encouraged to develop a continuum of care for Medicaid members with serious mental illness in lieu of traditional inpatient and outpatient Medicaid benefits.
2. MCOs must have an adequate network of public and private behavioral health providers.
3. When the level of care requested by the providers is recommended by the assessment instrument, the in-network provider should notify the MCO within one business day and no prior authorization is

² Greene, J. and Hibbard, J. (2013, February). What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health Affairs*, 32, 207-214.

required to deliver the service package. Only deviations from the assessment instrument may require authorization by the MCO and all prior authorizations must meet parity requirements.

4. HHSC should develop a system, in collaboration with MCOs, to improve the efficiency and consistency of the credentialing process and to ensure prompt payment for in-network provider organizations that hire new staff, starting on the date the new staff person is available to see the MCOs' members.

Why is access to behavioral health services a critical element for Medicaid members with mental health conditions?

Community based behavioral health services are a cost-effective way to provide treatment in a person's home and community. The average cost per day of a community-based services is \$12 for adults and \$13 for children, as compared to \$401 for a State Hospital bed, \$137 for a jail bed for an inmate with mental illness and \$896 for an emergency department visit.³ In addition to cost, these services are provided in the least restrictive setting for Medicaid members.

d. Administrative Simplification

Providers in a managed care environment often discuss issues requiring administrative simplification. This was a topic of considerable discussion at the BHIAC. There were many examples of increased costs of doing business due to the administrative complexities of dealing with managed care organizations and particularly around dealing with multiple managed care organizations.

Statewide, HHSC contracts with 19 managed care organizations, which may have different processes for providers to follow to be credentialed in the network, receive authorization for services, receive payment or denials for services and to appeal decisions. In addition, many of the plans subcontract behavioral health services to a different plan, with different processes. The additional administrative complexities discussed by the workgroup were identified as not adding value to the system but they did add cost to the provider.

Recommendations for Administrative Simplification

1. HHSC should require a uniform Prior Authorization process across all MCOs.
2. HHSC should require MCOs to respond to authorization requests within 2 business days and authorizations should be retroactive to the date and time of the request for Mental Health Rehabilitation and Targeted Case Management services.
3. HHSC should require MCOs to follow authorization guidelines for services and determination of medical necessity as defined by the State for Mental Health Rehabilitation and Targeted Case Management services. These guidelines should be developed in conjunction with MCOs, providers and other stakeholders.
4. HHSC should require MCOs to have a robust and simple formulary and a standard process across plans.

³ *Impact of Proposed Budget Cuts to Community-Based Mental Health Services*, Health Management Associates, March 2011.

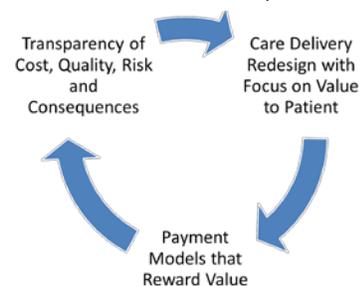
5. MCOs should be transparent with HHSC and providers on their utilization management policies and practices.

Why is administrative simplification for community behavioral health service providers a critical element for Medicaid members with mental health conditions?

The state of Texas has a shortage of behavioral health professionals, particularly psychiatrists and psychiatric mental health nurse practitioners. When professionals find themselves spending time and adding costs to their care due to increased administrative complexity, the likelihood of the professional continuing to participate in the insurer’s network decreases. With the shortage of behavioral health professionals, HHSC should make every effort to simplify the administrative processes for providers in order to increase the likelihood that Medicaid members in need of behavioral health services have access to and choice in providers.

e. Payment Mechanisms

Traditional fee-for-service provider reimbursement models are used in both the Texas Medicaid fee-for-service and the Medicaid managed care program. These type of payment models reimburse for specific approved services each time that specific service is delivered. The services are based on traditional delivery models: physician visits, counseling sessions, mental health rehabilitation services, and targeted case management. In the current payment environment, there are many services provided in an integrated setting that are not reimbursed, such as: provider-to-provider communication, phone conversations with members, services provided by multiple providers in the same group on the same day, member navigation and care coordination.



In addition, the current payment contracts may be broken out into two separate contracts with two separate MCOs. When a MCO contracts with the state for the Medicaid program, they may also subcontract behavioral health services to a BHO. In that case, a provider with an integrated clinic must negotiate separate contracts for physical and behavioral health services and bill separate MCOs for one member’s care.

When discussing barriers to integration, the BHIAC spent the most time discussing the barriers created by the current payment mechanisms in the Medicaid program. Innovative health care practices must be accompanied by innovative payment practices or the health care practices are not sustainable.

Recommendations for Payment Mechanisms

1. MCO and provider contracts should align financial incentives across physical and behavioral health. Payments should align with improvements in overall health quality and slowing of overall healthcare costs.
2. Payment rules and requirements should facilitate expansion of models of care that encourage behavioral health providers and physical health providers to co-manage members in a team-based model.
3. Integrated provider sites should be reimbursed through one contract with the MCO, even when the MCO subcontracts with a BHO.
4. In pilot sites, new payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex health conditions to achieve recovery

Why are innovative payment mechanisms required to support integration?

Value-based payment models focus on innovation to promote value over volume and integration over duplication. Physicians and provider organizations are responsible for the quality of services delivered and can take a value over volume approach but MCOs must create a payment environment that makes the transformation possible and sustainable. The ultimate goal is for the State, providers, MCOs, and members to work together to improve the value of services for members and achieving meaningful health outcomes.⁴ Without a change in payment mechanisms, providers will deliver what the MCO will authorize and pay for, regardless if it is the service that would have the greatest impact on member outcomes.

f. Outcome Measurement

If we are to achieve significant gains in increasing quality and decreasing cost, a consistent approach to measuring improvement is essential. The ability of the provider to focus on quality strategies is diminished when each funding agency and health plan defines and measures quality in different ways. A coherent approach to measuring quality is essential to accountability at all levels.

In addition, the focus must be on continuous quality improvement. The environment must allow for both success and failure, as long as failure is used as the opportunity to create change. Transparency of quality must be valued not feared. System transformation takes time and there will be unintended consequences; therefore, it is important to build in flexibility and provide positive reinforcement: incentivize, not penalize. Also of importance is the quality and number of outcome and process metrics, not output metrics, identified. Output metrics provide little help in quality improvement. The right outcome and process metrics gathered will be extremely useful, but the committee strongly encourages not implementing too many metrics. The result will be burdensome and counterproductive. A few key metrics, well used, have the capability to facilitate true change.

⁴ Porter, M. & Lee, T. (2013, October). The strategy that will fix health care. *Harvard Business Review*. Retrieved from <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>

In Texas, there are 3 main payers for behavioral health services for persons with serious mental illness and children with serious emotional disturbance:

- HHSC for Medicaid Managed Care (through contracts with multiple MCOs)
- DSHS for the indigent population and specialty services
- HHSC for the Medicaid 1115 Transformation Waiver for low-income Texans

Among the state Health and Human Services agencies, the approach to measuring outcomes for people with mental illness and/or substance use disorders and other chronic conditions varies. In the 2013 DSHS contract, contractors reported on 14 adult, 14 children and 19 other process and outcome measures. These measures were developed and defined by DSHS. HHSC measures managed care organizations typically through national data sets. The Medicaid 1115 Transformation Waiver uses a set of nationally recognized outcome measures and the provider selects the measure most appropriate for the project and population.

Recommendations for Outcome Measurement

1. Outcome measures should support a positive continuous quality improvement process and incentivize accountability at the state, MCO, provider and member level. A biennial review of metrics should be considered to ensure the metrics being gathered are fostering a successful integrated health care delivery model. MCOs and providers, with the support of HHSC, must develop mechanisms to share data on common members while Health Information Exchanges (HIE) in local communities are under development.
2. Measures should be tailored to meet the needs of children, young adults, adults, and the elderly.
3. All MCOs should assess their baseline level of integration, identify strategies to address areas needing improvement, and periodically assess integration improvement and its quality.
4. Member, provider, and MCO satisfaction measures should be monitored and openly distributed to facilitate feedback and transparency.
5. HHSC's philosophy in outcome reporting should be a public, transparent process to increase dialogue on integration, track changes over time, identify strategies to increase integration and describe what is happening in a community.

Why are outcome measures a required critical component to integrating care?

Measuring health outcomes are integral to assessing the quality of care; and are extremely useful in quality improvement, public reporting, and incentive programs. Accounting for all factors that influence an individual's health outcomes is challenging, but can be addressed by adjusting for risk factors, using statistical adjustment, or stratification of the data. In quality improvement, outcome measures can help identify areas in need of improvement. With this information, improvement efforts can be focused and target the gap, inefficient, or poorly performing areas where improvement might yield the best results. Implementing all three major uses of outcome measures together will facilitate the transformation of the current behavioral health care delivery system into a person-centered responsive fully integrated health care delivery system.

g. State Oversight

Between March 2012 and August 2013 (18 months), HHSC reported payments of \$21 billion to 18 managed care organizations and three dental MCOs.⁵ The Managed Care Organizations are a significant stakeholder in the Texas Medicaid program. The MCOs manage care for millions of Medicaid members and the number and types of services being managed continues to grow. The state's role and responsibility for oversight of these contracts also continues to grow and is integral to ensuring transparency and accountability in the system.

Recommendations for State Oversight

1. HHSC should develop a coordination plan for behavioral health services that includes all HHS agencies, along with other partnering agencies such as housing, education and criminal justice.
2. HHSC should routinely evaluate the adequacy of the MCO's network through a structured review process, with a focus on whether or not the provider is accepting new members.
3. HHSC Ombudsman staff should be thoroughly trained on the MCO contracts and have the ability to answer questions and assist with complaints in a timely and responsive manner.
4. HHSC Contract Management department should more actively engage Medicaid members and organizations when a complaint is filed against a MCO. The Medicaid member, provider and MCOs should all play an equal role in the process.
5. The Behavioral Health Integration Advisory Committee should continue to advise HHSC on integration as the Medicaid program continues to integrated care.
6. HHSC should actively seek stakeholder input on the Medicaid Benefit Policy Review for utilization management practices related to SB58. The process should move as expeditiously as possible.

Why is state oversight of the managed care organizations a critical element for Medicaid members with mental health conditions?

The oversight role of the Health and Human Services Commission is critical to Medicaid members with mental illness and their families and to providers of behavioral health services in the Medicaid program. Barriers to accessing services or payment to providers can significantly impact whether a member has timely access to quality services. Although managed care organizations are a significant stakeholder in the Medicaid program, they are not the only stakeholders. Medicaid members, Medicaid providers and behavioral health advocacy organizations are also significant stakeholders. HHSC has a responsibility to oversee the MCO operations and to have processes in place to assist Medicaid members, providers and advocates with a complex system.

The committee is concerned that the elimination of the Behavioral Health Integration Advisory Committee will impede the transformation of the system and hamper HHSC's ability to have meaningful stakeholder input into the process of integrating care. This report recommends high-level policy changes but many decisions must be made as operational procedures are written. Without the BHIAC, or another committee with similar membership, HHSC will not have a stakeholder voice in the process of

⁵ HHSC Medicaid/CHIP HMO Financial Summary FY 2013-90-day. March 2012 to August 2103. All Funds.

implementation. For example, HHSC will issue detailed requirements for Health Home pilots. The detailed requirements will determine how pilots are developed and implemented. Although the BHIAC has provided recommendations, without more detailed discussions with HHSC, it is difficult to ensure the intent of the recommendations in this report are understood. The BHIAC can provide continuity of feedback to HHSC from high-level policy to operational procedures if it is not eliminated.

h. Health Home Pilots

A “health home” offers coordinated, holistic health care services to Medicaid members with multiple chronic health conditions, including mental health and substance use disorders. SB 58, signed into law in 2013, requires health home pilots for Medicaid members with serious mental illness and at least one other chronic health condition. There are differences between a “patient-centered medical home” and a “health home”.

	Medicaid Health Home	Patient-Centered Medical Home
Target Population	Individuals with chronic conditions	All populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, federally qualified health centers, and other safety-net providers	Typically defined as physician-led primary care practices, but may include other primary care providers such as nurse practitioners
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)
How Care is Organized	Team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care	Team-based, whole person orientation achieved through coordinated care
Provider Requirements	State Medicaid determined	State Medicaid and National Committee for Quality Assurance determined
Payment	Usually PMPM for six required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

Source: SAMHSA-HRSA Center for Integrated Health Solutions

According to Senate Bill 58, all behavioral health services provided under the provisions of the bill are based on an approach to treatment where the expected outcome of treatment is recovery. The federal agency responsible for mental health policy, SAMHSA, defines ten guiding principles of recovery: Hope, Person-Driven, Many Pathways, Holistic, Peer Support, Relational, Culture, Addresses Trauma, Strengths/Responsibility and Respect. Health home pilots offer a focused approach to moving to a more coordinated, holistic manner of treatment with an expected outcome of recovery.

States have developed a variation of models of health home programs. Payment for health home services and staffing requirements vary by state. Required health home positions are typically associated with the payment rate set for health home functions described by the state in the state Medicaid plan amendment. In addition to required health home positions, states require the medical and long-term care services available to all Medicaid members in that state. Four state requirements for staffing for the health home are highlighted in the table below.

State	Iowa	New York	Missouri	Oklahoma
Required Health Home Positions	Access to Care Coordinators, Nurse Care Managers, Peer Support Specialists/Family Support Specialists, MD/DOs	Medical, Mental Health, Chemical Dependency, Social Worker, Nurses, dedicated Care Manager	Nurse Care Manager, Health Care Home Director, PCP Consultant, Care Coordinator	(Medium to Low) Health Home Director, Nurse Care Manager, consulting PCP, Psychiatric Consultant, Certified Behavioral Health Case Manager, Wellness Coach, Administrative Support (High) Required positions for medium to low and in addition: other licensed behavioral health professional, substance abuse treatment specialist, employment specialist
Optional Health Home Positions	Not specified	Nutritionist/Dietician, Pharmacists, Outreach Workers including Peer Specialists and other representatives appropriate to meet enrollees needs	Additional treatment team members including peer specialists billed through Medicaid state plan	Not specified

Recommendations for Health Home Pilots

1. HHSC should determine the outcome measures for assessing health home pilots in advance of operations. This process should include an informed group of stakeholders, including Medicaid members with mental illness, MCO, providers, advocates, peers, and academia.
2. Health homes should be comprehensive and should have the capacity to provide holistic, person-centered care with a focus on recovery.
3. New payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex health conditions to achieve recovery.
4. A quantitative and qualitative evaluation of the pilots must be built in from beginning to end. The evaluation should address process and outcomes clinically, administratively, and financially to facilitate the decision of taking lessons learned from the pilots to scale.
5. Health homes, and their MCO partners, must establish a continuous quality improvement program and report on outcomes measures to support evaluation of the model.

6. Learning collaboratives and other support structures should be developed to assist provider practices in the development of a health home pilot.
7. In selecting pilot sites, HHSC should include both urban and rural areas when feasible.

Why a health home model for Medicaid members with serious mental illness and at least one other chronic health condition?

Health homes are being established across the country as a care delivery system designed to improve the health outcomes of Medicaid members with complex needs. Eleven states have established Medicaid state plan amendments for health homes for Medicaid members with mental illness. In the first 18 months of the Missouri health home statewide project, they found a 12.8% reduction in hospital admissions and an 8.2% reduction in emergency room use per 1000 Medicaid members enrolled. The Missouri evaluation concludes the program has both improved the health status of Medicaid members in the program, while reducing costs.⁶

IV. Next Steps

The completion of this report meets the required statutory responsibility of this committee, however we believe this is the first step in the work of integrating care. The members of this committee strongly recommend the continuation of the Behavioral Health Integration Advisory Committee. Integrating care is a process that must be developed, implemented and evaluated with the input and expertise of a broad range of stakeholders: State staff, MCOs, providers, Medicaid members, advocates, peers and researchers. The BHIAC brings those stakeholders together to guide the work that will ultimately achieve better outcomes for Medicaid members in treatment, a better experience for providers and Medicaid members, and ensure cost containment for the Texas Medicaid program.

⁶ *Progress Report, Missouri CMHC Healthcare Homes (2013)*. Department of Mental Health and MO Healthnet.

V. Appendix A. List of Committee Members

Behavioral Health Integration Advisory Committee Members				
Salute	First Name	Surname	Credentials	City
**Dr.	Octavio	Martinez	MD, MPH, MBA, FAPA; Executive Director, Hogg Foundation for Mental Health	Austin
*Ms.	Melissa	Rowan	Healthcare Policy Director - Texas Council of Community Centers; Master's in Social Work, Administration and Planning	Austin
Mr.	Doug	Beach	Parent	San Antonio
Ms.	Michele	Bibby	Certified Peer Support Specialist	Pflugerville
Dr.	Susan	Calloway	Ph.D., MSN, PMHNP-BC, FNP-BC; Board member of Texas Rural Health Association, Parent, and Texas Tech University Health Science Center	Austin
Mr.	Terry	Crocker	CEO - Tropical Texas Behavioral Health; Master's degrees in Business and Psychology	Mission
Ms.	Sherry	Cusumano	RN, Licensed Chemical Dependency Counselor; MS in Healthcare Mgmt; ED of Community Education and Clinical Development	Dallas
Ms.	Kristen	Daugherty	CEO, Emergence Health Network; Master's Degree in Social Work, Licensed Clinical Social Worker; Master's in Business Administration	El Paso
Dr.	Lisa	Doggett	MD, MPH; Medical Director for El Buen Samaritano and Advisory Board member/former Medical Director for the McKesson Texas Medicaid Wellness Program	Austin
Dr.	Angelo	Giardino	MD, PhD, MPH; Vice President/Chief Medical Officer, Texas Children's Health Plan	Houston
Dr.	John	Gore	Senior Medical Director for Cigna-HealthSpring STAR+PLUS Pediatrician	Euless

Behavioral Health Integration Advisory Committee Members				
Salute	First Name	Surname	Credentials	City
Ms.	Debra	Jackson	CEO, Deblin Health Concepts & Assoc., Inc.	Houston
Mr.	Kenneth	Meyer	CFO/COO and Interim CEO Value Options of Texas, Inc.	Allan
Ms.	Dwina	Bridgemohan	Professional Mediator	Katy
Dr.	Richard	Noel	MD; Psychiatrist, Alternative Services Network; Medical Director, IntraCareNorth Hospital (free-standing Psychiatric Hospital)	Houston
Ms.	Janet	Paleo	Consumer Representative	San Antonio
Dr.	Nakia	Scott	MD; Child and Adolescent Psychiatrist, Holistic Mental Health, Director. Member Texas Society of Child and Adolescent Psychiatry.	Round Rock
Mr.	Gregg	Sherrill	Local Market Lead - Medicaid/Medicare for OptumHealth Behavioral Services. Licensed Professional Counselor; Master's in Counseling.	Katy
Dr.	John	Theiss	Ph.D. Vice Chair for Public Policy and Chair Elect, Mental Health America of Texas	Austin

** Indicates Chair of the Committee

* Indicates Vice Chair

VI. Appendix B. BHIAC Phase I and Phase II Final Recommendations

<p>Holistic Treatment</p>	<ol style="list-style-type: none"> 1. All Managed Care Organizations (MCOs) must have integrated technology systems and care coordination systems for physical and behavioral health, even when the MCO subcontracts for behavioral health services. 2. Technology should be leveraged to allow all providers and MCOs to have electronic access to a member’s full medical record without compromising confidentiality. 3. Care transitions from inpatient to outpatient and from outpatient to inpatient settings must be well coordinated. MCOs must emphasize coordinated discharge planning. HHSC should provide focused attention and oversight on the contract requirements related to discharge planning. 4. HHSC should use the term “Medicaid member” rather than “consumer” in written materials and oral presentations when discussing Medicaid beneficiaries, regardless of their health condition or diagnosis.
<p>Member Activation</p>	<ol style="list-style-type: none"> 1. Medicaid members must receive clear and linguistically appropriate information on their options in selecting a managed care plan and a provider, along with accurate information on which in-network providers are accepting new members. 2. Medicaid members should have easy access to understandable information on physical and behavioral health conditions, and how to maintain health and wellness. This should include innovative technology solutions for accessing individual health records and opportunities for self-care. 3. MCOs should encourage and provide support for enhanced communication with the member and, when appropriate, the member’s family. 4. Information provided to Medicaid members should include contact information for the HHSC Ombudsman as a point of contact for questions, concerns or complaints. 5. Program or health plan changes should be clearly conveyed to members, advocacy groups and providers. MCOs should be encouraged to include members, advocacy groups and providers on their board or advisory groups. 6. Medicaid members should be encouraged and incentivized to seek help to improve overall health.

<p style="text-align: center;">Access</p>	<ol style="list-style-type: none"> 1. MCOs should be encouraged to develop a continuum of care for Medicaid members with serious mental illness in lieu of traditional inpatient and outpatient Medicaid benefits. 2. MCOs must have an adequate network of public and private behavioral health providers. 3. When the level of care requested by the providers is recommended by the assessment instrument, the in-network provider should notify the MCO within one business day and no prior authorization is required to deliver the service package. Only deviations from the assessment instrument may require authorization by the MCO and all prior authorizations must meet parity requirements. 4. HHSC should develop a system, in collaboration with MCOs, to improve the efficiency and consistency of the credentialing process and to ensure prompt payment for in-network provider organizations that hire new staff, starting on the date the new staff person is available to see the MCOs' members.
<p style="text-align: center;">Administrative Simplification</p>	<ol style="list-style-type: none"> 1. HHSC should require a uniform Prior Authorization process across all MCOs. 2. HHSC should require MCOs to respond to authorization requests within 2 business days and authorizations should be retroactive to the date and time of the request for Mental Health Rehabilitation and Targeted Case Management services. 3. HHSC should require MCOs to follow authorization guidelines for services and determination of medical necessity as defined by the State for Mental Health Rehabilitation and Targeted Case Management services. These guidelines should be developed in conjunction with MCOs, providers and other stakeholders. 4. HHSC should require MCOs to have a robust and simple formulary and a standard process across plans. 5. MCOs should be transparent with HHSC and providers on their utilization management policies and practices.
<p style="text-align: center;">Payment Mechanisms</p>	<ol style="list-style-type: none"> 1. MCO and provider contracts should align financial incentives across physical and behavioral health. Payments should align with improvements in overall health quality and slowing of overall healthcare costs. 2. Payment rules and requirements should facilitate expansion of models of care that encourage behavioral health providers and physical health providers to co-manage members in a team-based model. 3. Integrated provider sites should be reimbursed through one contract with the MCO, even when the MCO subcontracts with a Behavioral Health Organization (BHO). 4. In pilot sites, new payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider

	<p>communication, care coordination and care of members with complex health conditions to achieve recovery.</p>
<p>Outcome Measurement</p>	<ol style="list-style-type: none"> 1. Outcome measures should support a positive continuous quality improvement process and incentivize accountability at the state, MCO, provider and member level. A biennial review of metrics should be considered to ensure the metrics being gathered are fostering a successful integrated health care delivery model. MCOs and providers, with the support of HHSC, must develop mechanisms to share data on common members while Health Information Exchanges (HIE) in local communities are under development. 2. Measures should be tailored to meet the needs of children, young adults, adults, and the elderly. 3. All MCOs should assess their baseline level of integration, identify strategies to address areas needing improvement, and periodically assess integration improvement and its quality. 4. Member, provider, and MCO satisfaction measures should be monitored and openly distributed to facilitate feedback and transparency. 5. HHSC's philosophy in outcome reporting should be a public, transparent process to increase dialogue on integration, track changes over time, identify strategies to increase integration and describe what is happening in a community.
<p>State Oversight</p>	<ol style="list-style-type: none"> 1. HHSC should develop a coordination plan for behavioral health services that includes all HHS agencies, along with other partnering agencies such as housing, education and criminal justice. 2. HHSC should routinely evaluate the adequacy of the MCO's network through a structured review process, with a focus on whether or not the provider is accepting new members. 3. HHSC Ombudsman staff should be thoroughly trained on the MCO contracts and have the ability to answer questions and assist with complaints in a timely and responsive manner. 4. HHSC Contract Management department should more actively engage Medicaid members and organizations when a complaint is filed against a MCO. The Medicaid member, provider and MCOs should all play an equal role in the process. 5. The Behavioral Health Integration Advisory Committee should continue to advise HHSC on integration as the Medicaid program continues to integrated care. 6. HHSC should actively seek stakeholder input on the Medicaid Benefit Policy Review for utilization management practices related to SB58. The process should move as expeditiously as possible.
<p>Health Home Pilots</p>	<ol style="list-style-type: none"> 1. HHSC should determine the outcome measures for assessing health home pilots in advance of operations. This process should include an informed group of stakeholders, including Medicaid members with

	<p>mental illness, MCO, providers, advocates, peers, and academia.</p> <ol style="list-style-type: none">2. Health homes should be comprehensive and should have the capacity to provide holistic, person-centered care with a focus on recovery.3. New payment structures should incentivize and support person-centered care, member satisfaction, provider-to-provider communication, care coordination and care of members with complex health conditions to achieve recovery.4. A quantitative and qualitative evaluation of the pilots must be built in from beginning to end. The evaluation should address process and outcomes clinically, administratively, and financially to facilitate the decision of taking lessons learned from the pilots to scale.5. Health homes, and their MCO partners, must establish a continuous quality improvement program and report on outcome measures to support evaluation of the model.6. Learning collaboratives and other support structures should be developed to assist provider practices in the development of a health home pilot.7. In selecting pilot sites, HHSC should include both urban and rural areas when feasible.
--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

VII. Appendix C.

HHSC Actions to Date on Phase I Recommendations

Recommendation Areas	BHIAC Phase I Recommendation	HHSC Action to Date
Holistic Treatment	1. All Managed Care Organizations (MCOs) must have integrated technology systems and care coordination systems for physical and behavioral health, even when the MCO subcontracts for behavioral health services.	HHSC will more fully develop this recommendation once behavioral health integration medical policy is completed.
Holistic Treatment	2. MCO and provider contracts should align financial incentives across physical and behavioral health. Payments should align with improvements in overall health quality and slowing of overall healthcare costs.	HHSC will more fully develop this recommendation once behavioral health integration medical policy is completed.
Holistic Treatment	3. Payment rules and requirements should facilitate expansion of models of care that encourage behavioral health providers and physical health providers to co-manage members in a team-based model.	HHSC will more fully develop this recommendation once behavioral health integration medical policy is completed.
Holistic Treatment	4. Technology should be leveraged to allow all providers and MCOs to have electronic access to a member's full medical record without compromising confidentiality.	HHSC will consider this recommendation once behavioral health integration medical policy is completed.

Holistic Treatment	5. Care transitions from inpatient to outpatient and from outpatient to inpatient settings must be well coordinated. MCOs must emphasize coordinated discharge planning. HHSC should provide focused attention and oversight on the contract requirements related to discharge planning.	HHSC will more fully develop this recommendation once behavioral health integration medical policy is completed.
Access	1. MCOs should be encouraged to develop a continuum of care for Medicaid members with serious mental illness in lieu of traditional inpatient and outpatient Medicaid benefits.	HHSC will more fully develop this recommendation once behavioral health integration medical policy and the results from the health home pilots are completed.
Access	2. MCOs must have an adequate network of public and private behavioral health providers.	HHSC requires in the Medicaid Uniform Managed Care Contract (UMCC) that MCOs have an adequate network of public and private behavioral health providers. HHSC Health Plan Management monitors MCOs on a quarterly basis for network adequacy based on self-reporting data from the MCOs in comparison to HHSC data analytics numbers and conducts desk reviews and secret shopper calls. In addition, HHSC has required all MCOs to report on a monthly basis the number of public and private providers they have in their networks for Mental Health Rehabilitative and Mental Health Targeted Case Management services.

Access	3. When the level of care requested by the providers is recommended by the assessment instrument, the in-network provider should notify the MCO within one business day and no prior authorization is required to deliver the service package. Only deviations from the assessment instrument may require authorization by the MCO and all prior authorizations must meet parity requirements.	This recommendation is included in the Medicaid Uniform Managed Care Manual (UMCM). HHSC developed this policy as a result of feedback provided from the BHIAC during the Phase I implementation of Senate Bill 58.
Access	4. HHSC should develop a system, in collaboration with MCOs, to improve the efficiency and consistency of the credentialing process and to ensure prompt payment for in-network provider organizations that hire new staff, starting on the date the new staff person is available to see the MCOs' members.	HHSC will work with the BHIAC and MCOs to develop a system to improve the efficiency and consistency of the credentialing process once behavioral health integration medical policy is completed.
Administrative Simplification	1. HHSC should require a uniform Prior Authorization process across all MCOs.	HHSC adopted a requirement for a uniform prior authorization process across all MCOs. This decision was made in conjunction with recommendations and feedback from the BHIAC and finalized March 1, 2015.
Administrative Simplification	2. HHSC should require MCOs to respond to authorization requests within 2 business days and authorizations should be retroactive to the date and time of the request for Mental Health Rehabilitation and Targeted Case Management services.	HHSC requires in the UMCM that authorizations be retroactive to the date and time of the request for Mental Health Rehabilitation and Targeted Case Management services. However, at this time HHSC will not be changing the timeframe for prior authorization requests which is currently 3 business days in the UMCC.

<p>Administrative Simplification</p>	<p>3. HHSC should require MCOs to follow authorization guidelines for services and determination of medical necessity as defined by the State for Mental Health Rehabilitation and Targeted Case Management services. These guidelines should be developed in conjunction with MCOs, providers and other stakeholders.</p>	<p>HHSC requires Medicaid MCOs in the UMCC to follow the current Department of State Health Services (DSHS) utilization management guidelines. HHSC is in the process of developing behavioral health integration medical policy which will include MCOs, providers and other stakeholders input.</p>
<p>Administrative Simplification</p>	<p>4. HHSC should require MCOs to have a robust and simple formulary and a standard process across plans.</p>	<p>HHSC requires a standard formulary across all MCOs. MCOs can only implement clinical edits with HHSC approval. In addition, HHSC has the Texas Drug Utilization Review Board which is an advisory board to HHSC and consists of practicing physicians and pharmacists who are appointed by the HHSC Executive Commissioner. The DUR Board reviews and approves the therapeutic criteria for prospective DUR, retrospective DUR, and clinical prior authorization edits.</p>
<p>Administrative Simplification</p>	<p>5. MCOs should be transparent with HHSC and providers on their utilization management policies and practices.</p>	<p>HHSC requires in the UMCC that MCOs receive approval when implementing any new policies that impact utilization management and are required to notify providers at least 30 days before implementing changes to policies and procedures. In addition, MCOs must provide training to all providers and their staff in regards to MCO policies and procedures and place special emphasis on Mental Health Rehabilitative Services and the availability of Mental Health Targeted Case Management for qualified Members, and the processes for making referrals and coordination with Non-capitated Services.</p>

State Oversight	1. HHSC should develop a coordination plan for behavioral health services that includes all HHS agencies, along with other partnering agencies such as housing, education and criminal justice.	HHSC's office of Mental Health Coordination under the direction of Sonja Gaines, the HHSC Associate Commissioner for Mental Health Coordination, is working on coordination of mental health services across all state agencies.
State Oversight	2. HHSC should routinely evaluate the adequacy of the MCO's network through a structured review process, with a focus on whether or not the provider is accepting new members.	HHSC requires in the Medicaid Uniform Managed Care Contract (UMCC) that MCOs have an adequate network of public and private behavioral health providers. HHSC Health Plan Management monitors MCOs on a quarterly basis for network adequacy based on self-reporting data from the MCOs in comparison to HHSC data analytics numbers and conducts desk reviews and secret shopper calls. In addition, HHSC has required all MCOs to report on a monthly basis the number of public and private providers they have in their networks for Mental Health Rehabilitative and Mental Health Targeted Case Management services.
State Oversight	3. HHSC Ombudsman staff should be thoroughly trained on the MCO contracts and have the ability to answer questions and assist with complaints.	HHSC Ombudsman office is aware of the Medicaid MCO complaints process and works very closely with HPM complaints.

<p>State Oversight</p>	<p>4. HHSC Contract Management department should more actively engage Medicaid members and organizations when a complaint is filed against a MCO. The Medicaid member, provider and MCOs should all play an equal role in the process.</p>	<p>HHSC updated the HPM complaint’s process based on stakeholder feedback and now requires that all parties of the complaint are actively engaged when a Medicaid member or provider files a complaint against an MCO. Members and Providers can file complaints at HPM_Complaints@hhsc.state.tx.us.</p> <p>In addition:</p> <ul style="list-style-type: none"> • MCOs must resolve Member Complaints received by HHSC and referred to the MCOs no later than the due date indicated on HHSC’s notification form. HHSC will provide MCOs up to ten (10) Business Days to resolve such Complaints, depending on the severity and/or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause. • MCOs must also notify HHSC’s Civil Rights Office of any civil rights complaints received. • The MCO must develop, implement and maintain a system for tracking, resolving and reporting member complaints regarding its services, processes, procedures, and staff. • The MCO is subject to remedies if at least 98 percent of member complaints are not resolved within 30 calendar days of the MCOs receipt. • The MCO must develop, implement and maintain a system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. • The MCO is subject to liquidated damages if at least 98 percent of
-------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

		<p>Member Appeals are not resolved within 30 days of the MCO's receipt.</p> <ul style="list-style-type: none">• MCOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider complaints.• The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the complaint by the MCO.
--	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

VIII. Appendix D.

Draft Recommendations Referred to Other Entities

**Health and Human Services Commission
Behavioral Health Integration Advisory Committee
Draft Recommendations Received and Referred to Other Entities
May 5, 2014**

Table 1: Draft Recommendations submitted by the public and members of the committee to be deleted, as determined through the workgroup process and committee discussion, but referred to other entities.

Category	Draft Recommendation(s) Deleted and Referred to Other Entities	Referred To
Managed Care Organization Contracts	Require all MCOs to adhere to a set of uniform contracting standards to include common referral requirements and authorization timelines	Health and Human Services
Managed Care Organization Contracts	It seems highly suspect that MCOs use "clinical criteria" not available in the public domain and published by a subsidiary of the very company that is using them.	Managed Care Advisory Committee
Managed Care Organization Contracts	Require all MCOs to demonstrate established connections w/ behavioral health specialists in rural and urban areas, using technology (such as video conferencing) when needed to ensure access to care. A plan of corrective action must be submitted when a behavioral health provider (or video conferencing capability) cannot be located within 75 miles of the member's residence	Managed Care Advisory Committee
HHSC Coordination and Oversight	HHSC will develop a report card based on outcomes and Medicaid member satisfaction and publish results making them available to the public. The same outcomes should be measured throughout the state allowing for easy comparison by Medicaid members and advocates. Valid complaints will be included on the report card.	Managed Care Advisory Committee to improve public access
HHSC Coordination	Oversight should be persistent and focused on outcomes with deeper investigation / review instituted when outcome	Managed Care Advisory

Category	Draft Recommendation(s) Deleted and Referred to Other Entities	Referred To
and Oversight	problems are identified. Service quality oversight should be an MCO responsibility with random and non-intrusive look back, plus more intensive follow up and oversight when/if problems are identified. Oversight should be primarily locally based with state support and TA when needed.	Committee
HHSC Coordination and Oversight	HHSC should routinely evaluate the adequacy of a MCOs provider network (both providers and facilities)	Managed Care Advisory Committee
HHSC Coordination and Oversight	HHSC should increase its monitoring of the provider network to determine if it meets adequacy requirements, with a focus on whether or not the provider is accepting new members.	Managed Care Advisory Committee
HHSC Coordination and Oversight	HHSC should develop routine oversight meetings	HHSC Associate Commissioner for Mental Health Coordination
HHSC Coordination and Oversight	There have been issues with defining mental health “medical necessity” for some time. All the MCOs use different definitions, and while these are public, still very vague. It may be difficult to integrate physical and mental health when we don’t have a good standard of what necessitates mental health intervention. The council needs to research this issue and determine how best to define medical necessity in a more standard way.	Managed Care Advisory Committee
HHSC Coordination and Oversight	I think an ACO approach to where there's an organization accountable for quality that isn't incentivized to withhold money rather than giving money to individual groups to manage care where they're essentially incentivized to withhold care so they can save money for their bottom line rather than demonstrate quality outcomes which I challenge any of the MCOs to actually produce evidence of providing at this time.	Managed Care Advisory Committee
HHSC Coordination and Oversight	HHSC to develop a more reliable and effective method of determining eligibility for Medicaid and CHIP coverage	Medicaid Advisory Committee
HHSC Coordination and Oversight	Enforce, “no wrong door” approach where the client is helped to gain services regardless of where they attempt to enter the	HHSC Associate Commissioner for Mental Health

Category	Draft Recommendation(s) Deleted and Referred to Other Entities	Referred To
	system	Coordination
HHSC Coordination and Oversight	Tear down silos between mental and physical health by organizing HHSC into health not mental health and physical health subdivisions	HHSC Associate Commissioner for Mental Health Coordination
HHSC Coordination and Oversight	Provide funding for research to solicit recommendations from focus groups within HHS agencies regarding issues that have arisen due to “working in silos”. These are the individuals that can articulate where there are service barriers, duplication of services and a lack of services.	HHSC Associate Commissioner for Mental Health Coordination
HHSC Coordination and Oversight	HHSC will need to adjust LMHA’s service targets to reflect the changes in Medicaid member choice. Process will need to be clear on entry points for services. LMHA’s currently conduct intake screenings and link clients to services allowing for choice of provider.	Department of State Health Services
HHSC Coordination and Oversight	The council needs to look at how the state funds mental health. MHMRs are on one budget line item and state hospitals are on another. Currently, it is in the best interest of the MHMR to place a child in a state hospital (SH) versus a community based hospital (CBH) because of the drain on their budget line item. This creates a conflict when state beds are full. If a child is placed at a CBH, it is temporary until they can be transferred to a SH. This makes it difficult for the CBH providers to determine how best to provide services. It is also disruptive to a child’s continuum of care. If the state could look at the mental health budget more holistically, better decisions could be made for care. This would also up the access by including more of the community providers. DSHS is currently “contracting” community beds due to shortage – not sure which line item that relates to so cannot offer comment as to being a resolution.	HHSC Associate Commissioner for Mental Health Coordination
Stakeholder Communications	All homeless shelter providers, case managers, and PSH agencies as well as city-funded HOMES program grantees and their Medicaid eligible recipients should receive in-person training sessions as well as a printed manual with access to	Department of State Health Services

Category	Draft Recommendation(s) Deleted and Referred to Other Entities	Referred To
	electronic resources to gain information regarding the changes in coverage.	

BHIAC: Behavioral Health Integration Advisory Committee