

MAINE BEHAVIORAL HEALTH MANAGED CARE
PROGRAM
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONCEPT PAPER

**For Public Comment and Discussion:
A Work in Progress
December 13, 2005**

**This is a discussion paper meant for comment and reaction.
Comments may be sent via e-mail to Chris.Zukas-Lessard@Maine.gov or in writing
c/o, Chris Zukas-Lessard, DHHS, #11 State House Station, Marquardt Building., 2nd
Floor, Augusta, Maine 04333-0011.
There will also be public meetings held around the state to provide opportunity for
reaction, questions and discussion about the issues this paper raises. More about
that soon for the month of January.**

TABLE OF CONTENTS

I.	INTRODUCTION	4
II.	PURPOSE OF THIS PAPER	4
III.	DESCRIPTION OF CURRENT SYSTEM	5
IV.	GUIDING PRINCIPLES IN THE DEVELOPMENT OF THE NEW MANAGED CARE SYSTEM For the Consumer and Family For the Mental Health and Substance Abuse Delivery System Desired System Results	5
V.	PROCESS TO DATE	7
VI.	IMMEDIATE NEXT STEPS, PROJECT TIMELINE AND WORK PLAN	9
VII.	PHASES OF THE BEHAVIORAL HEALTH SYSTEM'S DEVELOPMENT	10
VIII.	POPULATIONS AND SERVICES TO BE INCLUDED IN THE MANAGED CARE CONTRACT AS OF JULY 1, 2006 Populations to be covered as of July 1, 2006 Services to be covered as of July 1, 2006 Additional Services Being Considered for Phase Two and Beyond Financing Mechanisms	11
IX.	STRUCTURE FOR A SINGLE BEHAVIORAL HEALTH SERVICES DELIVERY SYSTEM Functions of the State, MCO, Consumers and Families Contracting with Providers Pharmacy	13
X.	MEMBER SERVICES AND CONSUMER/FAMILY INVOLVEMENT Education of Consumers, Families and Providers Assistance with Enrollment/Registration Complaints, Grievances and Appeals	16

XI.	MCO AND PROVIDER ACCOUNTABILITY	18
XII.	UTILIZATION REVIEW, UTILIZATION MANAGEMENT AND COORDINATION OF SERVICES Utilization Review, Utilization Management (UM/UR) Coordination with Primary Care	18
XIII.	QUALITY – PERFORMANCE MEASURES AND OUTCOMES	19
XIV.	CONCLUSION	20
	APPENDIX A	21

MAINE BEHAVIORAL HEALTH MANAGED CARE PROGRAM
CONCEPT PAPER – A WORK IN PROGRESS
December 13, 2005

I. INTRODUCTION

The demand for coordinated services for consumers and families encouraged the Maine Department of Health and Human Services to seek a better behavioral health care delivery system, one which would foster creativity and increased responsiveness to the needs of Maine behavioral health care consumers and their families. Continued budget constraints further prompted investigation of more efficient service delivery mechanisms. In July 2005, the Maine State Legislature directed the DHHS to establish a behavioral health service delivery system throughout Maine by contracting with a single Managed Care Organization (MCO), focused on the improvement and coordination of service provision and delivery (LD 468). The new contract is expected to be in place by July 1, 2006.

The Department of Health and Human Services is developing a behavioral health delivery system that is customer and family directed, committed to recovery and resilience, able to integrate services across multiple systems, is accessible in a timely manner and community-based. The Department will focus on these goals and outcomes as it plans for the behavioral health needs and designs and contracts for services in Maine.

II. PURPOSE OF THIS PAPER

This paper describes a process and a concept to improve the design and delivery of publicly funded behavioral health care services in Maine. The paper is written to communicate to stakeholders, funders, and decision makers much of the work that has occurred since October 2005 by staff of the Department of Health and Human Services.

This paper also represents a commitment made in September of 2005 to behavioral health stakeholders in Maine: to provide periodic opportunities for anyone interested to provide input into the design of this new system of service delivery. There will be various planned public meetings with Department personnel for the purpose of hearing public reaction, and responding to questions and suggestions. Additionally, regularly scheduled meetings of the Consumer Advisory Group, the Quality Improvement Council, and Maine Association of Peer Support and Recovery Centers may be used to solicit public involvement.

This paper is a work in progress and represents the writings of the Behavioral Health Work Group (BHWG). It is a group consisting of the following representatives from DHHS:

Brenda Harvey, Deputy Commissioner for Integrated Services
Kim Johnson, Director of the Office of Substance Abuse
Jim Beougher, Director of the Office of Child and Family Services
Marya Faust, Acting Director of the Office of Adult Mental Health
Cathy Cobb, Acting Director of the Office of Elder Services
Joan Smyrski, Director of Children's Behavioral Health Services
Elsie Freeman, Medical Director
Marie Hodgdon, Director of Purchased Services
Chris Zukas-Lessard, Medicaid Special Projects Manager
Jay Yoe, Director of the Office of Quality Improvement
Kathy Bubar, Director of Systems Integration, Region I

We encourage interested persons to read and critique the concepts in this paper. The paper reflects the initial thinking of the BHWG. Comments are welcome and encouraged as we continue the process of creating a single behavioral health service delivery system throughout Maine. Once comments are received and considered, the paper will be revised and will serve as the basis for development of a request for proposals (RFP)/Contract and for further development of the single behavioral health system described in this paper.

As part of the development process, the staff reviewed prior efforts to improve the mental health and substance abuse delivery systems. Since the early 1990's a number of planning groups have been meeting and have produced plans that have been responsive to Federal requirements such as the Block Grant and State Requirements such as the consent decree and children's behavioral health system reform. A list of these groups and reports are available in Appendix A

III. DESCRIPTION OF CURRENT SYSTEM

The existing behavioral health care delivery systems in Maine present a fragmented and uncoordinated array of services, offering varying degrees of accessibility and quality of service delivery. There are areas of the state where there are too few providers or the existing providers are not able to provide the variety of services necessary to truly meet the needs of the population in the area. Additionally, there is little coordination between and among service providers in a given area to assure that the needs of the individuals in that area are met without a great deal of redundancy. Accountability to and improved outcomes for consumers and their families is lacking. The promise of an array of community- and home-based alternatives to institutional care has not materialized to the extent necessary despite aggressive planning. At the very least, the current system is cumbersome and confusing for consumers and families to navigate.

IV. GUIDING PRINCIPLES IN THE DEVELOPMENT OF THE NEW MANAGED CARE SYSTEM

Based upon the review of the current system and the plans previously developed, DHHS has developed the following principles to guide system change at all levels:

For the Consumer and Family

- Services will be individually centered and family-focused based on principles of individual capacity for recovery and resiliency;
- Each individual or family will direct his/her/their services to the extent possible.
- Treatment and services will be based on effectiveness and individual preferences.

For the Mental Health and Substance Abuse Delivery System

- Services will be delivered in a culturally responsive and respectful manner in the most appropriate, least restrictive mode (appropriate to their legal status), including home- and community-based settings wherever possible.
- Service planning and management will utilize individual and family abilities and strengths and, where appropriate, will be conducted in consultation with family, caregivers, and other persons critical to an individual's life and well-being.
- Services will be coordinated, accessible, accountable, and of high quality.
- Services will include behavioral health early intervention, treatment, community support, and activities that further recovery and resiliency.
- Care must focus on increasing consumers'/ families' abilities to successfully manage life challenges, on facilitating recovery, and on building resilience.
- Mechanisms will be in place to ensure continuous quality improvement.

In some cases, the individual goal of services provided is secondary to or co-existing with the community goals of preventing incarceration or re-incarceration or preventing behaviors that are inconsistent with community safety. While recognizing and embracing the importance of these additional goals, the managed care system will focus first on the best outcomes for the individual and family served and believes that by doing so, the additional system and community goals can also be met.

Desired System Results

Additionally, the Department has developed interim objectives that will guide the development of the managed care contract. The contracted MCO must be committed over time to achieving the following system results:

- Access to the right service in the right amount at the right time to meet the needs of individuals receiving mental health and/or substance abuse services;
- Coordinated funding that will be sufficiently flexible to promote a more efficient system of services and supports, including but not limited to a single billing

- process and consistent data collection, management and reporting systems, while meeting state and federal requirements;
- Development and use of a common age-appropriate assessment process and tool, and a single service plan for each individual and/or family receiving services, sufficient for all funding sources and used in all service settings;
 - Uniform program standards, including common service definitions, utilization management measurements/criteria, quality requirements, system performance expectations, and consumer/family outcomes;
 - Assurance of an adequate number and distribution of appropriately credentialed behavioral health care providers;
 - Implementation of evidence-based and best practice service approaches.
 - Improved access to all needed services, with an emphasis on access to substance abuse services;
 - Continuity of care for individuals with mental illness that allows for a smooth and timely transition from hospital to community and through appropriate levels of care;
 - Ability to meet State, State Judicial and Federal mandates.

V. PROCESS TO DATE

Shortly after the Legislature mandated that the Department move to behavioral health managed care for all MaineCare funded mental health and substance abuse services, the Behavioral Health Work Group was formed. The BHWG has guided and will continue to guide the development of the new behavioral health system until a contract with the MCO has been selected and is operational. At that point, the existing members of the work group, with the addition of a number of advisors nominated by and chosen from various advocacy and consumer groups will continue to guide the work on this initiative.

The following steps represent actions through December 9, 2005:

- A technical assistance visit from a team sent from the National Association of State Mental Health Program Directors to evaluate Maine's readiness for managed care indicated that Maine should be able to implement managed care within tight timeframes.
- After an evaluation of the various options, the determination has been made that a 1915(b) Freedom of Choice Waiver will provide the most flexibility in designing a program that will best meet the needs of the people of Maine.
- A limited period position for a MaineCare expert has been created and filled. This staff member will be responsible for drafting the waiver document and shepherding it through CMS.
- Prepared initial work plan and timeline that includes significant action steps and assignment to responsible staff members.
- The scope and purpose of the actuarial work has been defined and available options to get that work done are being explored. Mercer Government

Consulting, Inc. has been selected to perform this work and will be onsite the week of December 12.

- A contract has been signed with a consultant who has had significant experience in a managed care from both a financial and a programmatic prospective to work with the BHWG.
- The appropriate federal regulations that control many aspects of managed care programs have been identified and reviewed.
- Research into various models of managed care have been reviewed and evaluated for applicability in Maine. The BHWG will work from those models to design a program for Maine that meets all of the requirements of the Consent Decree as well as the needs of the people in Maine who utilize the public behavioral health system. The states that have been evaluated include New Mexico, Arizona, Pennsylvania, Connecticut, Massachusetts and Utah. Components of Florida's program, especially the consumer directed services, are also being evaluated and considered.
- Met with Court Master and plaintiffs' counsel to ensure continuity between the consent decree and managed care implementation.
- The BHWG met in a two-day session to determine the appropriate roles and responsibilities of the Department and the MCO under this new arrangement.

VI. IMMEDIATE NEXT STEPS, PROJECT TIMELINE AND WORK PLAN

The Department is committed to having a single behavioral health service delivery system in place, through a partnership with a MCO, by July 1, 2006. In order to meet this commitment, the following immediate actions are necessary:

- By December 15, 2005 develop concept paper for review by the Court Master, and consumer and provider groups. Revise as necessary and appropriate.
- During the week of December 12, 2005, the BHWG meets with Mercer Government Consulting, Inc.
- During the week of December 12, 2005, revise project timeline, assign subject area experts to CMS waiver application and project work plan.
- By January 3, 2006, begin drafting MCO contract including scope of work (service delivery and expectations), special terms and conditions, and financial and programmatic monitoring.
- By winter 2006, a final Request for Proposals/Contract will be released.
- Vendor selection will occur with contracting and transition plans completed by late spring 2006.
- Federal approvals will be sought during the winter of FY 2006.
- By early 2006, complete actuarial work including development of capitation rates and databook.

The Department is also developing a detailed Project Implementation Timeline and Work Plan. The timeline and work plan will include timeframes for completion of specific sections of the 1915(b) Waiver and contract/RFP document, assignment of duties

to responsible DHHS staff, and deliverables. These documents will be available January 10, 2006.

This is an aggressive timeline especially given the necessity to seek federal approval of a 1915(b) Freedom of Choice waiver allowing the Department to move to managed care. The Department is committed to continually evaluating progress towards implementation and will adjust priorities and seek additional assistance as necessary.

VII. PHASES OF THE BEHAVIORAL HEALTH SYSTEM'S DEVELOPMENT

It is important to understand that July 1, 2006 is just the beginning of a much longer process. System change of this magnitude is not something accomplished with the flip of a switch or on a particular day. Rather, on July 1, 2006, a new system *begins*. It will take a number of years beyond that time to evolve the partnerships, relationships, and expectations of this new behavioral health service system to become what the stakeholders and state leadership want the single behavioral health service delivery system to be in Maine. As a consequence, the evolution of this new system will be considered in phases.

The BHWG anticipates a planning and transition phase and at least three implementation phases in the evolution of this new single behavioral health delivery system.

Planning and Transition is already underway. Conceptualizing and planning for the new behavioral health delivery system began as soon as the Legislature announced the behavioral health initiative. Planning continues with the work of the BHWG and the development of this concept paper. The most significant step of the transition process includes the development of the request for proposals or a contract that will define the design of the system and role of the MCO. The development of a Quality Strategy and assuring that the outcomes and performance standards required by the Department will be specified in the contract for all mental health and substance abuse services.

Also during this phase, a public involvement process for planning and implementation will occur with consumers, families, providers and other stakeholders. Forums for all stakeholders will be held at various locations around the state to solicit input and comments. Using the staff of the Department, it is anticipated that a large number of forums can be held during January 2006 to assure in so far as possible that all voices are heard. And finally during this process, decisions for competition for the MCO contract and CMS waiver application will be made.

Phase One will begin July 1, 2006, and a contract for an MCO will be in place. This phase will cover the time period from July 1, 2006 through June 30, 2007 (FY 2007).

During this phase, the Department will work with the MCO to assure continuity of care and services during the early months of the contract and a smooth transition to the

managed care service system. During this phase, transitional issues will continue to be addressed, and goals for Phase Two will be developed. Initial outcome measures and performance objectives will be in place and the MCO will be judged on its ability to meet those criteria.

Also during this phase, the Department and the MCO will work with local communities to help those communities come together to assure the ongoing continuity of care for all individuals in that community who receive services from the MCO. The Department is committed to the philosophy that communities know their needs and can work with the MCO to assure that those needs are met within the constraints of the available resources.

During Phase Two, lasting up to two years (July 1, 2007 through June 30, 2009), the staff from the MCO will work with representatives of the Departments of Corrections and Education to establish more effective ways of identifying multiple funding sources and funding mechanisms to support the outcomes of this program. Performance objectives and deliverables will continue to be developed, expanded and refined for each phase so that clear progress toward a comprehensive behavioral health system is accomplished.

Additional resources will be sought collectively by the State and MCO to address unmet needs and identified priorities for service expansions. Phase Two may also see the inclusion of additional funding streams and other resources, as well as additional services not included in the initial RFP.

Phase Three is anticipated to begin no later than July 1, 2009. By this time, the system should be maturing, performance and outcomes should be clear, and adjustments to the system can be undertaken based on those results. Any additional funding streams to be included in the responsibilities of the MCO will be included and all coordination with other related resources will have been accomplished.

VIII. POPULATIONS AND SERVICES TO BE INCLUDED IN THE MANAGED CARE ORGANIZATION CONTRACT

Populations to be covered as of July 1, 2006

There are more than 280,000 Maine residents enrolled in the MaineCare Program. More than 80,000 of these residents are receiving behavioral health services from one or more delivery system. Additionally, many residents are enrolled in state-only programs, often funded by the State's General or a variety of Federal Block Grants. All MaineCare eligibles are expected to be covered by the MCO as well as many of the adults and children covered by these other fund sources. These include the following categorical and non-categorical populations:

- Children ages 0 to through the 21st birthday

- Medicaid Eligible – welfare and non-welfare children, in or out of home, in state or out of state
- Wrap-around and grant funds
- Children receiving crisis services
- Adults Receiving Substance Abuse Services
 - Medicaid Eligible – both categorical and non-categorical
 - Non-Medicaid Eligible
- Adults with Serious and Persistent Mental Illness (SMPI)
 - Medicaid Eligible - both categorical and non-categorical
 - Bate’s Classmembers
 - Members currently served that may be in jail that are currently funded by DHHS
 - Dual Eligibles (Medicaid and Medicare)
- Adults with a General Mental Health Disorder
 - Medicaid Eligible
 - Non-Medicaid Eligible

Services to be Covered as of July 1, 2006

Relevant behavioral health services under the following chapters of the MaineCare Benefits Manual will be included in the initial MCO Contract:

- Chapter II – Section 13: Targeted Case Management (behavioral health services only)
- Chapter II – Section 17: Community Support Services
- Chapter II – Section 23: Developmental and Behavioral Clinic Services
- Chapter II – Section 37: Home Based Mental Health Services
- Chapter II – Section 40: Home Health Services (behavioral health services only)
- Chapter II – Section 45: Hospital Services (behavioral health services only)
- Chapter II – Section 46: Psychiatric Facility Services
- Chapter II – Section 55: Laboratory Services (behavioral health services only)
- Chapter II – Section 58: Licensed Clinical Social Worker, Licensed Clinical Professional Counselor and Licensed Marriage and Family Therapist Services
- Chapter II – Section 65: Mental Health Services
- Chapter II – Section 67: Nursing Facility Services (behavioral health services only)
- Chapter II – Section 80: Pharmacy Services (behavioral health services only)
- Chapter II – Section 90: Physician Services
- Chapter II – Section 96: Private Duty Nursing and Personal Care Services (behavioral health services only)
- Chapter II – Section 97: Private Non-Medical Institution Services (behavioral health services only)

- Chapter II – Section 100: Psychological Services
- Chapter II – Section 102: Rehabilitative Services (behavioral health services only)
- Chapter II – Section 111: Substance Abuse Treatment Services

Non-state plan services, like respite services to children and social clubs, will not be included at this time for any population.

Additional Services Being Considered for Phase Two and Beyond

The RFP may indicate that during Phase Two, utilization of additional services and funding will be added to the MCO's responsibilities. While no decisions have yet been made, services and funding being considered for inclusion in the MCO's responsibilities to coordinate or administer beginning in Phase Two include but are not limited to:

- Access to vocational rehabilitation and supported employment funding and services for adolescents and adults with behavioral health diagnoses;
- Access to housing resources for low-income individuals or persons with mental illness or substance abuse disorders;
- DHHS's TANF funds for substance abuse for TANF eligible individuals;
- DOE's funds for school based behavioral health services;
- DOC's funds for behavioral health services provided to incarcerated adults and juveniles;
- DHHS sexual assault services funding;
- Federal and foundation funding for prevention, early intervention, treatment or rehabilitation services, including housing and employment-related services for persons with mental illness and/or substance abuse, and their families;
- DHHS and other substance abuse and mental health prevention dollars
- Behavioral health funds and services provided through DHHS public health clinics,
- Transportation funds; and
- Early intervention services.

Any services provided through the state should be coordinated with the services and funding that are the responsibility of the MCO, whether the funding for those services are contracted to the MCO to administer or retained to be administered by state agencies. This means service definitions, service requirements, performance expectations, referral and follow-up, participation in and utilization of a single joint assessment and service planning process, early transition planning and coordination of transition from one service setting to another, data sharing, etc., must all be consistent or the same and/or shared throughout the behavioral health service delivery system.

Financing Mechanisms

Funding for the MCO will consist of a prepaid capitation rate for Medicaid services and a 1/12 allocation for non-Medicaid eligible individuals.

IX. STRUCTURE FOR A SINGLE BEHAVIORAL HEALTH SERVICE DELIVERY SYSTEM

Functions of the State, MCO, Consumers and Families

The initial plans regarding the functions of DHHS and the MCO are described briefly here:

DHHS: Develop and maintain the statewide behavioral health plan including planning to meet state and federal requirements; grant writing and management; the development of the State's Quality Strategy including performance and outcome indicator development and oversight; capitation and fee-for-service rate setting development and maintenance of service definitions; assuring consumer/ family/citizen input, planning, oversight and implementation of training and technical assistance; medical and clinical leadership; assuring the use of evidenced-based practices; fraud and abuse monitoring; and licensing and certification oversight.

MCO: Financial management and oversight; delivery of training; contracting with and monitoring providers; client outcomes; system outcomes; assuring consumer/family/citizen input; enrollment of recipients service development; coding and configuration; legal issues; establishing a single client identifier for data; utilization management (UM); trending UM data; utilization criteria predictive modeling/disease management guidelines; prior authorization (for certain services); quality management and improvement; interpreter services; provider services; member services (including formal grievances and appeals); claims management/billing/payment; data management; fraud and abuse; regulatory compliance; and implementation and maintenance of provider credentialing.

Consumers and Families: Involved in all aspects of contract development and oversight of the MCO and its providers; identification of unique barriers and solutions, and advising DHHS and the MCO about improved ways to seek and obtain consumer and family involvement.

This initial structure will be refined as stakeholders are brought into the development process. Additionally, care coordination services and other issues may affect decisions about structure.

In preparing a Request for Proposals (RFP) and the contract for the MCO, consideration will be given to those elements that support consumers and families and incorporate long-term planning to address the gap between what is needed and what is provided. At a minimum, the RFP/Contract will include the following approaches:

- Stakeholder engagement – Clients, families and advocates engaged and involved in all aspects of the public behavioral health care system, from governance and policy development through planning and program development to quality management and system evaluation. Stakeholders are the most effective advocates for the vision and mission of the public behavioral health care system. They also provide the motivation and momentum for the change process.
- Data for decision-making – Accurate, timely and consistent data gleaned from a variety of sources will be used to drive system planning, budgeting, and quality management and performance evaluation, with decisions at all levels based on consistent analyses and interpretations of accurate and timely data.
- Incentives and Rewards – Formal and informal incentives to “do the right thing” which are consistent with the vision of the system. These could include resources, recognition, attention, mentoring and sanctions to encourage the system and its components to perform in the desired way.
- Quality improvement culture – An organizational and system-wide culture that fosters and supports constant learning, change, challenging long held principles, and trying out new ideas throughout the public behavioral health care system.
- Accountability – Accountability is a cornerstone of this reform. The contract will include specific deliverables including service and administrative requirements. The contract will also include specific system performance and consumer outcomes that must be met and consequences if they are not. These will form the basis of contract oversight of the MCO by DHHS.

The key functions of the MCO can be summarized as:

- Contracting and paying providers;
- Utilization review and utilization management;
- Assuring access to services in a timely manner;
- Evaluation and monitoring of providers and services;
- Member services including grievance and appeals;
- Establishment and maintenance of a sufficient provider network;
- Quality review and improvement – achieving system performance and consumer outcomes; and
- Collecting, managing and reporting data required by fund sources and for quality management purposes.

Because of the short time frame that Maine has to implement this program, a request will be made to the Federal Medicaid agency (CMS) to sole source this contract for the MCO. However, this request may not be approved and the Department will be required to develop a Request for Proposals (RFP) to solicit competition.

Contracting with Providers

The MCO will contract with behavioral health providers or groups of providers for the delivery of behavioral health services. In the process of developing contracts with providers to assure services are delivered according to consumer and family needs certain

providers will be considered essential. That means the MCO will need to maintain a contract or method of payment with these providers for the appropriate clients.

For at least Phase One, in order to maintain continuity of care and system stability, the MCO will be expected to contract with all current providers who meet requirements and who receive state-controlled funds as of June 30, 2006. After a specified time (six months to one year), the MCO will not be required to contract with any willing provider and will be free to develop contracts with providers or groups of providers as needed to accomplish the goals of the contract. Any decision-making process about providers or groups of providers who will receive contracts will be based on the need to create the best services and access to services possible within available resources. The process must represent a fair selection among willing providers.

Decisions by the MCO regarding what providers it will contract with in addition to existing providers in Phase One and in addition to essential providers ongoing will be guided by input from consumers and families and by requirements that DHHS may choose to establish.

Pharmacy

DHHS has determined that it is important to include the management of behavioral health medications within the responsibilities of the MCO. Organizations that manage care have been known to negotiate and purchase medications at rates that are more economical than states purchasing medications on their own. MaineCare currently uses a Preferred Drug List and is working with the private sector to control pharmaceutical costs. The MCO will be required to achieve comparable or improved financial and therapeutic results for behavioral health recipients currently managed under the MaineCare PDL program.

X. MEMBER SERVICES AND CONSUMER/FAMILY INVOLVEMENT

“Members” refers to those individuals who are receiving services from the managed care behavioral health system, whether as a person who is entitled to certain services, or as a person who has been accepted into services after requested or being referred for services. How the new system provides information and resolution of customer concerns will be a key quality indicator for DHHS. Federal and state requirements guide some of the expectations for Member Services. The Department’s philosophy, values and principles also guide expectations in the areas of education, assistance in member enrollment, outreach, customer representatives/services, and complaints, grievances and appeals processes.

Maine currently has active consumer groups and consumers who provide services as paid professionals. As the new system is designed and begins operating, the state agencies are committed to consumer and family involvement in the new system at all levels.

Education of Customers, Families and Providers

The MCO, together with the Department, will be responsible for providing education, training and technical assistance to customers, providers and key stakeholders.

Preliminary topics for these activities include:

- Scheduling region-specific education and assistance to customers and providers regarding the state's publicly funded behavioral health system;
- Developing an educational/training curriculum in collaboration with individuals and families;
- Providing ongoing training and education regarding a benefit package of services, including: behavioral health and substance abuse information; provider education; and billing codes, processes and procedures;
- Disseminating the principles and core values of the new behavioral health system, particularly the concepts of recovery, resiliency and empowerment;
- Developing educational materials that include ways those consumers and their families may access information and services;
- Providing clearly written informational materials designed and distributed with consumers and families in mind;
- Disseminating policies and procedures to customers and providers regarding the complaint, grievance and appeals processes that are compliant with federal and state laws, regulations, guidelines and consent decree/settlement agreement requirements; and
- To the extent possible, standardizing the complaint, grievance, and appeals process so that it is the same regardless of payer source or funding.

Assistance with Enrolling/Registration

The MCO and providers will establish a uniform, well coordinated intake process that, in addition to keeping the intake streamlined and user friendly, will also assess the customer's need for the full array of available behavioral health services. If the new process changes significantly from the existing process, the MCO will seek prior approval from DHHS.

Complaints, Grievances and Appeals

The Department shall establish clearly defined policies and procedures for complaints, grievances and appeals, so that individual and family concerns are addressed promptly and uniformly.

An early warning system shall be designed and utilized for tracking trends or patterns in complaints, grievances, appeals, service denials, access issues and/or other pertinent monitoring mechanisms. The warning system should include:

- Identified trends or recurrent customer or provider complaints, grievances and/or appeals shall be subject to sanctions.

- Inclusion of individuals and families providing monitoring, oversight and feedback to the MCO and providers regarding performance and/or need for improvement.
- The state shall establish a tracking and data collection system that will capture all behavioral health payer sources. DHHS shall document, track and resolve issues and provide reports that ensure and enforce compliance.
- The state shall use as its baseline for the complaint/grievance and appeal process the proposed Medicaid Member Grievance Resolution Process as well as the requirements found in the Rights of Recipients Of Mental Health Services, the Bates consent decree and any other rule or regulation that currently dictates how the Department will manage complaints and grievances.

XI. MCO and PROVIDER ACCOUNTABILITY

- The state shall include in the contract with the MCO and shall require the MCO to include in its contract(s) with providers clearly defined, contractually enforceable sanctions so that if the MCO and providers does/do not perform according to agreed-upon standards and expectations, correction or remedy will be possible.
- The MCO shall be subject to oversight by the Department to evaluate or review performance and shall make available such data and individuals necessary to determine whether the entity is meeting contract requirements.
- Negative trends or poor performance by the MCO and providers shall receive prompt attention and response that includes specific, enforceable timeframes for resolution of identified problems; and the possibility of monetary withholds or penalties.
- Consumers and their families shall have specific meaningful roles in assessing quality of services and in reviewing quality and utilization review data, including aggregate data about consumer complaints, grievances and appeals.

XII. UTILIZATION REVIEW, UTILIZATION MANAGEMENT, COORDINATION OF SERVICES

Utilization Review and Utilization Management (UM)UR)

UR/UM can be a way of assuring that limited dollars are used most effectively but, more importantly, done right, UR/UM can help assure the individuals and families get their needs met and that services are the right ones for those individuals and families. UR/UM can also be a way to identify groups or types of individuals who are not receiving the appropriate services and, as a result, are not having their needs adequately met.

Within the new system, the Department will establish utilization review and utilization management policies to guide the development of the MCO's UR/UM strategies. DHHS shall approve the MCO's policy for prior authorization of services.

Uniform definitions, clinical criteria, processes and procedures will be used throughout the state for prior authorization or review of specific services for an individual or family, whether before or after the fact. Some populations and some services may be reviewed only retrospectively as part of a quality management process, while other services (especially out-of-home or extremely costly services) are likely to require authorization prior to service delivery.

Coordination with Primary Care

Maine has multiple initiatives that support the integration of physical health care with mental health and substance abuse care. The State Health Plan defines health broadly, as inclusive of both physical and emotional well-being, and supports the integration of mental health screening and treatment into the objectives of the health plan. Finally, the state health plan supports the use of the care model as a means of addressing chronic conditions, including chronic behavioral health conditions.

As part of its contract, the MCO will be responsible for:

- Documenting evidence of having an ongoing, productive relationship with existing initiatives on integrated mental health/substance abuse/physical health care;
- Developing objectives related to improving the health status of persons with serious mental illness or substance abuse, and also objectives related to improved integration and quality of MH/SA screening and treatment in primary care settings. Developing performance goals that track utilization and quality of medical care, coordination of care between behavioral health and physical health providers and the overall health status of our consumers with serious mental illness or substance abuse.
- Developing performance goals that document the quality of screening and treatment for common psychiatric ailments in primary care, starting with the quality of depression care and screening for substance abuse.

XIII. QUALITY- PERFORMANCE MEASURES AND OUTCOMES

First and foremost, the commitment to recovery and resilience will drive the outcomes the Department seeks from the services it funds. *Services are not the end being sought; they are the means to that end.* The end for individuals and families with mental illness or substance abuse disorder, just as for anyone, is a satisfying productive life in the community. Mostly, persons with mental illness or substance abuse disorder need a place to live, a job to do or a successful school or developmental experience, sufficient income to meet basic needs and socializing opportunities with friends or relationships. Society (taxpayers, community leaders, legislators) want to make sure that people with mental illness and/or substance abuse disorders are not disruptive to the community, the costs of providing care are reasonable and funds are not spent on ineffective services or activities. Service providers want to be assured they are being paid quickly, that the result

of doing business is worth the cost and the outcomes are meeting the demands of funders and service users.

The challenge for the Department is to develop a system performance measures and consumer/family outcome measures that satisfy different audiences or different purposes. As part of the transition and planning phase, the Department and others will inventory all the current performance measures and decide what measures will be included in the MCO contract.

These measures will be incorporated into a quality improvement strategy to assure that data is used to monitor both system performance and consumer/family outcomes, consumers and family members have meaningful roles in that monitoring and that this monitoring is used to make changes to improve the system designed and purchased. The MCO will have a critical role in helping to track and monitor the system and to guide the changes that need to be made. The Department will include specific deliverables and performance requirements in the contract with the MCO as well as monetary and other sanctions to assure accountability.

Overall concepts that are being considered include the following: regulatory and statutory performance requirements; access to care standards, appropriateness of care; functional outcomes; prevention services transitions of care; care coordination; credentialing and licensing; data collection and required reports, complaints and grievances; behavioral health clinical criteria; fraud and abuse; behavioral health encounter data and quality management and improvement.

XIV. CONCLUSION

This paper provides a preliminary structure for the single behavioral health delivery system to be purchased pursuant to the requirements of the Maine Legislature. The paper recognizes that while the current way of providing and funding services will change on July 1, 2006, that date is only the beginning. This change is an evolution. It will take many years, much stakeholder involvement, continuing efforts to improve and a great deal of patience to reach our state's goals.

This change will be a challenging one to put into place. There will be growing pains as we learn together how to design, implement and oversee a single behavioral health delivery system for children, adults and seniors regardless of location or degree of need. However, this change has the potential to significantly improve the lives of persons receiving behavioral health services throughout Maine.

Appendix A

Advisory Groups:

Adult Mental Health Services Consumer Advisory Committee

The Statewide Quality Improvement Council

Maine Association of Mental Health Services

Hospital and Crisis Initiative Group

Reports:

The Consent Decree Plan for Bates vs. DHHS

Transform ME: A Strategy for Prevention, Resilience, and Recovery
Mental Health Transformation State Incentive Grant
Application submitted to SAMHSA.... June 1, 2005

State Health Plan

Muskie Study on Behavioral Health Care Costs

Best Principles for Managed Care Medicaid RFP's
American Academy of Child and Adolescent Psychiatry

Best Principles for Measuring Outcomes in Managed Care Medicaid Programs
American Academy of Child and Adolescent Psychiatry

Stand and Deliver: Action Call to a Failing Industry
Laura Lee Hall, Ph.D., Elizabeth R. Edgar and Laurie M. Flynn

Medicaid Managed Behavioral Health in Rural Areas
Maine Rural Health Research Center

Overview of Publicly Funded Managed Behavioral Health Care
Mardi Coleman, William Schnapp, Debra Hurwitz, et.al.

Managing Managed Care for Publicly Financed Mental Health Services
Bazelon Center for Mental Health Law

New Freedom Commission Report - 2003

Executive Summary

During the last legislative session, the Department of Health and Human Services was mandated by the legislature to design and implement a MaineCare Behavioral Health Managed Care program. The goals of this program were to both save money and to improve the service coordination to individuals who utilize the public mental health system.

In order to comply with this mandate, a group of individuals representing all of the programs in the Department that will be effected by this change began to meet to design the program. The individuals involved in this effort are:

Brenda Harvey, Deputy Commissioner for Integrated Services
Kim Johnson, Director of the Office of Substance Abuse
Jim Beougher, Director of the Office of Child and Family Services
Marya Faust, Acting Director of the Office of Adult Mental Health
Cathy Cobb, Acting Director of the Office of Elder Services
Joan Smyrski, Director of Children's Behavioral Health Services
Elsie Freeman, Medical Director
Marie Hodgdon, Director of Purchased Services
Chris Zukas-Lessard, Medicaid Special Projects Manager
Jay Yoe, Director of the Office of Quality Improvement
Kathy Bubar, Director of Systems Integration, Region I

In addition to representatives from the Department, two consultants, Leslie Schwalbe and Suzanne Gelber, representing expertise in both behavioral health managed care and substance abuse services, have assisted in this design effort.

There are a number of decisions that have been made and a number that are still being considered and will be based on input from a wide group of consumers, families, and providers, all of whom will receive this concept paper and be asked to comment. The givens for the first year of the program are:

- All individuals receiving publicly funded behavioral health services will be included in the Program.
- For at least the first year:
 - All providers will be eligible to be network providers.
 - The array of services will not change.
 - State hospitals will not be included in the managed care program.
- Consumers will not be denied necessary services of the kind or in the quantity that they need. "Need" will be based on clinical assessment as well as the consumer's evaluation of their well-being.
- Performance measures and all other applicable terms from the Consent Decree will be built into the MCO contract.

Some of the decisions that are pending additional input include the inclusion of additional funding streams into the Program, the inclusion of prevention dollars and the expansion of performance objectives to assure that the Department is purchasing the most efficient and effective services available.

The ultimate goal of this Program is the provision of the right service in the right amount at the right time to promote recovery and resilience in those who use the publicly funded behavioral health system in Maine.