Department of Legislative Services

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FISCAL AND POLICY NOTE
First Reader

House Bill 938 (Delegate Rosenberg)
Health and Government Operations

Behavioral Health Transformation Act of 2019

This bill requires the Maryland Department of Health (MDH) to expand the current delivery system for specialty mental health services to include specialty *behavioral* health services and expands the required components of the system. The Secretary of Health must modify and reissue Request for Proposals No. MDH/OPASS 20-18319, issued November 29, 2018 ("Administrative Services Organization for Maryland's Public Behavioral Health System") to incorporate the provisions of the bill.

Fiscal Summary

State Effect: Significant operational impact and indeterminate fiscal impact on State expenditures to reintegrate behavioral health services back into a managed care system, as discussed below. Potential increase in special fund revenues from the 2% premium tax on managed care organization (MCO) capitation rates beginning as early as FY 2020.

Local Effect: The bill does not directly impact local government finances or operations.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Primary behavioral health services" means the clinical evaluation and assessment of mental health and substance use disorder services needed by an individual and the provision of mental health and substance use disorder services or referral for additional mental health and substance use disorder services as determined medically appropriate by a primary care provider. "Specialty behavioral health services" means any

mental health and substance use disorder services other than primary behavioral health services.

In addition to current requirements, the delivery system must:

- assume *full financial risk*;
- provide all specialty *behavioral* health services needed by enrollees, as well as underinsured individuals, and uninsured individuals, including services not covered by Medicaid;
- provide a single point of contact and uniform processes for provider credentialing, claims processing, payment, and formulary and service authorization;
- reimburse providers at a rate that adequately compensates for costs incurred and minimizes unnecessary administrative burden;
- measure, collect, and report on quality of care outcomes;
- compile specified outcomes data;
- coordinate with local behavioral health authorities and local health departments;
- manage provider network and participation processes that support quality care;
- provide value-based payments for participating providers;
- reimburse providers for services delivered in the Institutions for Mental Disease;
- comply with federal and State insurance parity laws;
- provide fair, impartial, and timely internal and external grievance and appeals processes;
- serve all eligible individuals, regardless of age; and
- ensure opportunities for stakeholder involvement in system design, management, and oversight.

Current Law: The Secretary of Health may establish a program under which Medicaid recipients are required to enroll in MCOs. MDH must establish a delivery system for specialty mental health services for MCO enrollees. The Behavioral Health Administration (BHA) must design and monitor the delivery system, establish performance standards for providers, and establish procedures to ensure appropriate and timely referrals from MCOs to the delivery system. MDH must collaborate with MCOs to develop standards and guidelines for the provision of specialty mental health services. MDH may contract with an MCO for delivery of specialty mental health services if the MCO meets performance standards adopted by MDH in regulations.

The delivery system must (1) provide all specialty mental health services needed by enrollees; (2) for enrollees who are dually diagnosed, coordinate the provision of substance abuse services provided by MCOs; (3) consist of a network of qualified mental health professionals from all core disciplines; (4) include linkages with other public service

systems; and (5) comply with quality assurance, enrollee input, data collection, and other requirements specified by MDH in regulation.

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires group health plans of large employers, as well as qualified health plans sold in health insurance exchanges and in the small group and individual markets as of January 1, 2014, to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways. MHPAEA prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those imposed on other general medical benefits. MHPAEA also imposes nondiscrimination standards on medical necessity determinations.

Maryland's mental health parity law (§ 15-802 of the Insurance Article) prohibits discrimination against an individual with a mental illness, emotional disorder, or substance use disorder by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply for the diagnosis and treatment of physical illnesses.

Background: MCOs currently cover mental health and substance use disorder services provided by an enrollee's primary care provider. As part of Maryland's § 1115 HealthChoice waiver, specialty mental health and substance use disorder services (services that are not part of a primary practitioner's office visit) are "carved out" into a separate managed fee-for-service (FFS) system administered by BHA, local core service agencies, and an administrative services organization (ASO).

In total, about 300,000 people receive specialty mental health and substance use disorder services annually through the specialty mental health system (SMHS), 96% of whom are Medicaid enrollees. SMHS currently serves some non-Medicaid eligible individuals (underinsured and uninsured) and provides some services not covered by Medicaid (*i.e.*, supported employment) using State dollars.

The Governor's proposed fiscal 2020 budget includes $5.2 billion for MCO capitation rates and $1.5 billion for provision of specialty mental health and substance use disorder services to Medicaid enrollees.

The current five-year ASO contract for the SMHS expires December 31, 2019. The request for proposals for the next ASO contract was issued in November 2018 with bids due February 28, 2019. The contract will run January 1, 2020, through December 31, 2024, with one two-year option to cover January 1, 2025, through December 31, 2026.

The model proposed under the bill is similar to the behavioral health carve-out with insurance risk model adopted in Michigan in 2014 under which all substance use and

specialty mental health services were carved out from MCOs and delivered on a capitated basis through a contract with a behavioral health ASO/behavioral health organization. This type of carve-out assumes full financial risk for providing services.

State Fiscal Effect: Under the bill, the pending ASO contract would need to be modified and reissued to reflect changes to the new specialty behavioral health system (the current five-year contract costs approximately $95 million for the entire period). A new contract would need to be entered into that assumes full financial risk (as opposed to the current ASO contract that simply pays FFS claims). Capitation rates would need to be set for the contract, which could be accomplished through the current Medicaid rate-setting contract.

To the extent the new entity responsible for the system is structured like an MCO, Medicaid special fund revenues increase as early as fiscal 2020 as MCOs are subject to the 2% insurance premium tax. These revenues currently accrue to the Maryland Health Care Provider Rate Stabilization Fund and are used to support Medicaid operations.

However, the impact on overall State spending on behavioral health services under the bill cannot be reliably estimated. Although spending on behavioral health has increased in recent years, such increases cannot be attributed to those services being carved out of managed care. Several factors have influenced utilization, including the opioid epidemic, Medicaid enrollment growth under the federal Patient Protection and Affordable Care Act, and expanded access to services. It is unclear to what extent moving behavioral health services into a behavioral health carve-out with insurance risk as proposed under the bill would impact costs. Total spending on behavioral health could be maintained, increase, or decrease.

Small Business Effect: Several of the bill's provisions likely benefit small business mental health and substance use service providers, such as inclusion of services not covered by Medicaid, reimbursement of providers at rates that adequately compensate for costs incurred, and minimization of unnecessary administrative burden.

Additional Information

Prior Introductions: None.

Cross File: SB 975 (Senator Hayes) - Finance.

Information Source(s): Maryland Association of County Health Officers; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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