The Changing Face of Health Care

Health Policy Briefing for Montgomery County Leaders

Presented by: Leslie Graham, Primary Care Coalition, President and CEO
December 10, 2014
An Introduction to the PCC
About the Primary Care Coalition (PCC)

Mission:
Develop and coordinate a community-based health care system that strives for universal access and health equity for our low-income, ethnically diverse community members.

• Nonprofit with independent, volunteer Board of Directors
• 60+ employees
• Collaborate with DHHS, primary and specialty care providers, pharmacists, labs, and others to make available a culturally competent system of care
• Leverage public funding and foundation grants as the neutral entity

• Core competencies:
  – Program implementation and administration
  – Process/Quality improvement
  – Collaborative innovation
About Montgomery County

The Community:

- **High need/high capacity.** A generally wealthy county but with 70,150 residents living below the poverty line

- **Increasingly diverse.** 45% of residents are “minorities”; 40% speak a language other than English at home; 32% are foreign born

- **Civic-minded.**
  - Stable, non-profit hospital environment and extensive non-profit sector
  - Determined to “step up” to provide for poor and vulnerable populations

*Challenge is to leverage, align, and focus resources to achieve results.*

Data Source: U.S. Census Bureau, 2013 American Community Survey; Washington Post “Affluent Montgomery County has pockets of poverty, mostly in the east”, September 6, 2014
About the Primary Care Coalition (PCC)

What We Do:

• Foster and coordinate a high quality, efficient community-based health care system that is culturally competent

• Core programs administered by PCC currently serve more than 31,000* uninsured men, women and children
  – Administer safety-net health care programs for the uninsured (delivered through 12 clinic safety-net organizations, 6 hospitals, independent health care providers, & other community partners)
  – Coordinate specialty care referral network & medicine access
  – Provide integrated behavioral health services
  – Lead quality improvement across organizations to achieve chronic disease management, cancer screening and prevention metrics similar to a Medicaid plan
  – Facilitate community collaboratives to fill gaps and coordinate care

* An estimated 60,000 will remain uninsured after QHP Enrollment/Medicaid expansion
Operating a System of Care for Vulnerable Community Members

- **Montgomery Cares.** Primary and preventive care for low-income, uninsured adults (+specialty care & medicines)
  
  In Fiscal Year 2014:
  
  - 28,011 patients served
  - 63.5% below 100% FPL

- **Care for Kids.** Primary and preventive care for the uninsured children of low-income families
  
  In Fiscal Year 2014:
  
  - 3,024 children served
  - 62% below 100% FPL
100+ Active Partnerships

Including:

- Montgomery County Dept. of Health and Human Services
- Housing Opportunities Commission of Montgomery County
- Independent Primary Care Clinics (12)
- Hospitals (6)
- School-based health centers (8)
- Community-based organizations (40+)
- Private health care providers
- Foundations (25+)
- Academic Institutions (7)
Select Population Based Programs

Emergency Department to Primary Care Connect (2009 – 2011)

- Reduced avoidable ED use by connecting low-income uninsured patients who used a hospital emergency room to a safety-net clinics for ongoing care
  - $1,216,000 estimated reduction in ED visit costs for project patients referred between July 2009 and December 2010

Long Branch Place Based Initiative

- Established an integrated and coordinated network of health, social and support services to promote health equity among 48,000 low-income, culturally and ethnically diverse residents of the Long Branch Community in Silver Spring
  - 19+ partner organizations including 2 hospitals

H.E.A.L.T.H. Partners: Hospital to Home

- Improve care transitions from hospital to community, reduce preventable readmission to acute care hospitals, and reduce EMS calls among the elderly, low income residents of the Holly Hall apartment building in Silver Spring
  - 13+ partner organizations including all 4 hospital health systems
What Does the Future Hold?

- ~50,000 will gain coverage through Medicaid or a subsidized qualified health plan (QHP)
- 60,000 Montgomery County residents will remain uninsured
- Many low income Montgomery County residents will continue to have difficulty accessing health care, regardless of insured status
- Access to care for the newly insured will remain a challenge due to linguistic, cultural, literacy, and other barriers; some with insurance will still face access barriers due to high deductibles and copayments
- In Montgomery County, those who remain uninsured will largely be non-citizen immigrants ineligible for Medicaid or subsidized insurance
- Care coordination—especially for those with complex care needs—is essential
Contact

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Affordable Care Act Implementation
Capital Region Health Connector Entity

Ben Turner, PCC Capital Region Connector Performance Manager
Capital Connector Overview

Background:

- 1 of 6 connector entities in Maryland
- Serves Montgomery & Prince George’s Counties
- Marylanders eligible for ACA private coverage (QHPs) or Medicaid enroll through a state exchange: the Maryland Health Connection (MHC)
- Connector entities conduct outreach activities and provide enrollment support
Capital Connector Overview

Structure:
• Administered by Montgomery County Dept. of Health & Human Services (DHHS), in partnership with:
  – Prince George’s County Dept. of Social Services
  – Prince George’s County Health Dept.
• 18 subcontracted community-based organizations (see handouts for complete list)
• These partner agencies hire navigators, assisters, and outreach workers to promote the benefits of health coverage and help consumers enroll
• The PCC is the performance manager responsible for:
  – Data management and reporting
  – Process improvement
  – Facilitating communication
Open Enrollment Year One

Challenges:

• Electronic enrollment system underperformed
  – Limited ability of consumers to enroll on their own
  – Added pressure on enrollment workers to serve more people than anticipated and push through manual enrollments

• Lack of transparency regarding policies & communication regarding system problem

• Web-site and printed materials were available in English and Spanish; materials in other languages were produced locally

• Little state-sponsored publicity or promotion in the Capital Region

• Limited health insurance literacy & health literacy among target population: how to choose a plan and how to use insurance to access care
Open Enrollment Year One

Maryland enrollment rates:
• Nearly 352,000 people enrolled
• 79,000 into private coverage (QHPs)
• 273,000 net growth of Medicaid

Capital region enrollment rates:
• Approx. 108,000 residents enrolled
• Exceeding the goal of 52,156
• 32,000 into private coverage (QHPs)
• 76,000 net growth of Medicaid

Year One Enrollment Estimates
By Connector Entity Region

- Capital Region, 107,951
- Central Region, 124,181
- Western Region, 61,693
- Southern Region, 16,243
- Eastern Shore - Upper, 26,031
- Eastern Shore - Lower, 12,379

Data based on MHBE press releases.
Open Enrollment Year One

Capital region enrollment stats:
55,300 Montgomery County residents enrolled:
- 20,400 into private coverage (QHPs)
- 34,900 net growth of Medicaid

52,600 Prince George's County residents enrolled:
- 12,300 into private coverage (QHPs)
- 40,300 net growth of Medicaid

<table>
<thead>
<tr>
<th></th>
<th>Montgomery</th>
<th>Prince George's</th>
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<tbody>
<tr>
<td>Medicaid/MCHP</td>
<td>34,902</td>
<td>40,280</td>
</tr>
<tr>
<td>QHP</td>
<td>20,427</td>
<td>12,342</td>
</tr>
<tr>
<td>TOTAL</td>
<td>55,329</td>
<td>52,622</td>
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</tbody>
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Total Enrollments in Capital Region: by county & coverage type

Data based on MHBE press releases; analysis of data included in handouts.
Open Enrollment Year One

Who remains uninsured?

• 55,329 Montgomery County residents who enrolled do not represent a direct reduction in the number of uninsured
  – Many had other coverage before converting ACA coverage
• Estimated decline in uninsured rate in Montgomery County
  – 9% in 2013 to 7% in 2014
  – A reduction of roughly 26,000 people
• PCC estimates 60,000 Montgomery County residents will remain uninsured after full implementation of the ACA

Open Enrollment Year One

Capital Connector enrollment assistance:
• Navigators and assisters are responsible for approx. 25,600 enrollments through direct assistance at Montgomery County sites
  – Over 46% of all enrollments in Montgomery County
  – Many applicants could not enroll without assistance due to technical problems
• 25% of those enrolled with assistance were non-English speakers
  – Spanish, Korean, Amharic, and Vietnamese were the most common languages spoken
• Assisted enrollment in Montgomery County was evenly split between private coverage (QHPs) and Medicaid/MCHP
Open Enrollment Year One

Lessons learned:

• Technical and technological
  – Functional enrollment system is essential
  – Accurate, real-time data to proactively target efforts

• Language access and cultural competency
  – Population seeking enrollment assistance in Montgomery County is diverse
  – Information must be available in multiple languages
  – Enrollment platform must be available in multiple languages

• Communication and public information
  – Lack of clarity regarding state policies limited enrollment workers’ ability to help consumers
  – Great need for health literacy and health insurance literacy
Open Enrollment Year Two

New enrollment system:
• The MHBE changed the web-based platform for year two
• Adopted Connecticut’s successful system
• New system went live on November 15, 2014
• Benefits:
  – New system is more functional
  – Tens of thousands signed-up in the first week of open enrollment
• Drawbacks:
  – No auto-renewal for QHP enrollees
  – All who gained QHP coverage in Year One must start over
  – Manually re-apply for 2015 coverage
  – Deadline for re-enrollees to receive subsidy is December 18, 2014

QHP enrollees who do not renew by December 18, will be enrolled into a similar plan for 2015 but without subsidies.
Open Enrollment Year Two

51,796 enrolled from Nov 17-Dec 4
- 29,543 into QHPs
- 22,253 into Medicaid
- Montgomery County is top-ranked
- 11,964 enrollments from Nov 17-Dec 4
Open Enrollment Year Two

Capital Connector enrollment assistance through Dec 5

- Navigators and assisters have provided assistance to 3,927 people
- Completed enrollment application for 2,206 individuals
- Enrolled 1,351 Montgomery County residents

Note: Only data for applicants who enrolled through Capital Region navigators & assisters. This does not include data from other county case workers, the statewide call center, private brokers, or self-enrollment.

Montgomery
- Medicaid: 552
- Private Coverage (QHP): 799
- TOTAL: 1,351

Prince George's
- Medicaid: 415
- Private Coverage (QHP): 409
- TOTAL: 824
Open Enrollment Year Two

Capital Connector enrollment assistance November 17 to December 5:

Capital Region Language Diversity

- English: 45.1%
- Spanish: 24.7%
- Amharic: 6.4%
- Korean: 5.6%
- Chinese: 17.7%
- Vietnamese: 5.8%
- French: 5.6%
- Other/Multiple: 3.4%

Capital Region Racial/Ethnic Diversity

- Non-hispanic White: 41.9%
- Hispanic/Latino: 27.0%
- Black/African-American: 25.0%
- Asian or Pacific Islander: 2.4%
- Other or Multiple: 3.7%

Note: Only data for applicants who received assistance through Capital Region navigators & assisters. This does not include data from other county case workers, the statewide call center, private brokers, or self-enrollment.
Open Enrollment Year Two

Ongoing challenges:
• Still some technical and technological difficulties
  – Incorrect eligibility determinations
  – Bottlenecks in electronic enrollment process
• Lack of clarity on state policies, including Medicaid eligibility for several classes of lawfully present non-citizen immigrants
• Need for greater public awareness of the availability of subsidized health insurance through MHBE
• Need for public education on health insurance and how to use health insurance to obtain primary and preventive care
• Language access remains a priority for Capital Region
• Ambiguity regarding funding for 2015-2016 fiscal year
Community-Based Care Coordination

Julia Doherty, PCC Board Member; Director at L&M Policy Research
Jane Thompson, Health Care Consultant
Care Coordination – Getting the Best Results from the Best Care

- Fragmentation of overall health system leads to disconnects in care delivery and social service supports
  - Particularly acute for under-served and low income populations
- Many new models being implemented to minimize fragmentation
  - Care coordination/case management/medical homes
  - Navigation, transition & community support programs
- PCC activities:
  - Monitoring and research on new models
  - On-going care coordination and transition management
  - Testing small pilots of care coordination
What Care Coordination Looks Like

• Inform, educate, and encourage prevention and screenings
• Help people connect with the services they need
• Coordinate care plans for specific diseases/chronic conditions
• Facilitate teamwork among providers to optimize outcomes for a patient with multiple care needs:
  – Behavioral health and primary care
  – Specialist and primary care
  – Hospital or long-term care inpatient stays and primary care
  – Emergency rooms and primary care
• Connect/refer people to social and home services:
  – Housing, nutrition, wellness programs: exercise, smoking cessation
• Help manage and reconcile medications
## PCC’s Care Coordination Activities

<table>
<thead>
<tr>
<th>Care coordination activity</th>
<th>How it’s happening in MoCo</th>
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<tbody>
<tr>
<td>Behavioral Health and primary care</td>
<td>Montgomery Cares Behavioral Health Program</td>
</tr>
<tr>
<td>Specialist and primary care</td>
<td>Project Access</td>
</tr>
<tr>
<td>Hospital inpatient and primary care</td>
<td>HEALTH Partners</td>
</tr>
<tr>
<td>Emergency rooms and primary care</td>
<td>ED to PC Connect</td>
</tr>
<tr>
<td>Manage and reconcile medications</td>
<td>Medication Therapy Management</td>
</tr>
</tbody>
</table>
Innovative Thinking on the State Level

• Medicare Waiver All-Payer Model Changes
  – Shifts from payments for the number of services to payments for quality services (global hospital budgeting)
  – Requires hospitals to collaborate with community-based providers to improve patient outcomes and population health

• State Innovation Model (SIM)
  – Integrate clinical services with community supports
  – To improve overall population health
The 4 Pillar Conceptual Framework for Improving Access and Outcomes

• **Support Access to Primary Care** – especially for low-income elderly and disabled

• **Strengthen Community Health** – with integration of all community health resources including primary care and social services

• **Develop Workforce** - train, credential, and employ community health workers

• **Use Data Strategically** - to inform, manage, and improve care
Integrating Services for Health

Community Health Team

- Local Health Departments
- Community Organizations
- Social Services
- Hospitals
- Other providers

Primary Care Team

- Primary Care Physicians
- Nurse Practitioners
- Allied Health Professionals
- Community Pharmacists

* Adapted from Maryland DHMH State Innovation Model Implementation Proposal to CMS.
Taking the Montgomery County Experience to the Next Level

- PCC has deep knowledge and expertise working with health systems and vulnerable populations
- Successful integrator of fragmented health care services
  - Focused on both providers and patients
- Implementing, managing and improving existing and new programs
- Developing solutions to solve entrenched problems
Long Branch Health Enterprise Zone

Sharon Zalewski, VP for Health Care Access, Primary Care Coalition
Long Branch Health Enterprise Zone

About:

• Long-term, place-based initiative to reduce health disparities and improve outcomes
• High need, ethnically and economically diverse community
• Integrates health, social services and other community resources to improve community health and promote health equity
• Located in Maryland District 20
• Not an official Health Enterprise Zone
  – Began in 2012 to Community Health Resources Commission funding opportunity
  – Proposal scored well but was not funded
Long Branch Health Enterprise Zone

Goals:

- Improve the health status of the Long Branch community to:
  - Reduce incidence of and complications from diabetes
  - Reduce avoidable emergency room visits and preventable hospitalizations
  - Reduce health care costs
- Increase access to primary health care
- Expand the health care workforce and increase its cultural competence
- Improve coordination and effectiveness of health and community resources
Long Branch HEZ Coalition

Coalition Governance and Program Support
- PCC Program Management (Administrative and Fiscal)
- CHEER Program Coordination
- Montgomery County DHHS

Anchor Organizations
- Holy Cross Hospital Health Center
- Washington Adventist Hospital

Primary Care Partners
- Care for Your Health
- Community Clinic, Inc.
- Holy Cross Hospital Center Clinic at Montgomery College, Silver Spring
- Mary’s Center
- Mobile Medical Care
Community Partners

Healthy Life Styles
Adventist Community Services
Crossroads Community Food Network
Holy Cross Hospital Health Center
Washington Adventist Hospital

Health Work Force Development
Center on Health Disparities
Primary Care Coalition
Community Clinic, Inc., Mary’s Center, Mobile Med, Holy Cross Clinic, Care For Your Health
Work Force Solutions

Community Outreach
Casa de Maryland
DHHS Minority Health Initiatives
IMPACT Silver Spring

Community Development
CHEER: Community Health Improvement
Georgetown University: Evaluation, CPBR
MC Community Action Council: Volunteer Income Tax Assistance (VITA)
Faith-Based and CBOs: Micro Grant Programs
Impact of Diabetes in Long Branch

- Morbidity and mortality associated with diabetes and related conditions is a significant and well-documented health disparity.

- 12% of patients served by Montgomery Cares clinics have diabetes.
  - 14% among residents of Long Branch.

- Diabetes prevalence rates among blacks and Hispanics are significantly higher than among non-Latino whites.
  - 77% and 66% respectively.
  - A disparity of this level or greater is likely among the residents of Long Branch.

- The zip codes that comprise the HEZ have the highest rates of hospitalization for long-term complications of diabetes and uncontrolled diabetes.
  - Rates exceed the state median by one-third (30.4 v. 20.5 and 21.7 v. 12.4).
Primary Language of Diabetic Safety Net Patients in the HEZ

Number of Diabetic Patients = 371

Source: USGS National Atlas, PCC, Montgomery County
Map was created by Kathleen Rosenberg-Eckert
Strategies

• Support healthy lifestyles by establishing programs that focus on food, nutrition education, fitness activities, diabetes prevention and management

• Decrease fragmentation of pre-diabetic and diabetic care through prevention strategies, patient health education and access to care

• Coordinate, strengthen and expand the navigator network to promote community-based disease prevention, healthy behaviors and lifestyles and access to health related services

• Improve coordination among safety-net primary care providers and Holy Cross and Washington Adventist Hospital to reduce emergency department utilization for ambulatory sensitive conditions and improve hospital to home care transitions

• Increase the primary care provider workforce, increase its diversity and improve cultural competency
<table>
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<tr>
<th>HEZ Goals</th>
<th>Measures</th>
<th>Reportable Outcomes</th>
</tr>
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<tbody>
<tr>
<td>Reduce Risk Factor Prevalence and Improve Health Outcomes</td>
<td><strong>Primary</strong>: Standardized patient demographics, diabetes ED utilization and hospitalization rates, primary care utilization, diagnoses and indicators (HgA1c, LDL). <strong>Secondary</strong>: Body comp, BMI, Blood Pressure. <strong>Tertiary</strong>: Depression, other comorbid conditions.</td>
<td>Annual changes in diabetes ED utilization and hospitalization admission rates. Quarterly changes in HgA1c, LDL, BMI and Blood Pressure. Treatment/control of comorbid conditions.</td>
</tr>
<tr>
<td>Expand Primary Care Work Force</td>
<td><strong>Primary</strong>: Annual review of primary care work force, Provider demographics. <strong>Secondary</strong>: Community Asset Survey.</td>
<td>Annual increase in the number of primary care providers serving 20912 and 20913. Increase in diversity and language competency of providers and practices.</td>
</tr>
<tr>
<td>Increase Community Health Work Force</td>
<td><strong>Primary</strong>: Regular review of the disposition of navigators and health promoters, pre/post test data on HEZ-delivered standardized training on diabetes education, number of certified health promoters across partner organizations.</td>
<td>Annual increase in the number of certified health promoters in 20912 and 2013. Annual increase in the number of Certified Diabetes Educators. Biennial documentation of referrals and linkages to pcps and other health resources.</td>
</tr>
<tr>
<td>Increase Community Health Resources</td>
<td><strong>Primary</strong>: Community Asset Survey, pre/post test knowledge from Community Health Improvement Process, utilization of Fruit and Vegetable Prescription Program, exercise programs and local pool.</td>
<td>Annual community asset map w/HEZ metrics. Quarterly utilization reports for Fruit and Vegetable Prescription Program, exercise programs and subsidized pool program.</td>
</tr>
<tr>
<td>Reduce Avoidable ED Visits and Hospitalizations</td>
<td><strong>Primary</strong>: Analyses of ED utilization data (NYU Algorithm), Analysis of length of stays and readmits for diabetic patients. <strong>Secondary</strong>: Resident surveys.</td>
<td>Biennial reports of diabetic ED utilization and hospitalization. Quarterly reports of primary care utilization by HEZ diabetic residents.</td>
</tr>
<tr>
<td>Reduce Unnecessary Costs</td>
<td><strong>Primary</strong>: Estimate cost avoidance based on analysis of hospital utilization data and specialty care utilization.</td>
<td>Annual cost avoidance reports for reduction of avoidable hospital ED visits, reduction in diabetes hospitalizations and specialty care utilization.</td>
</tr>
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</table>
Resource Re-Investment and Sustainability

The value proposition
- Reduce overall health care costs through a coordinated approach to health care
- Redistribute health resources within a defined community to build and sustain programs that improve the overall health of the population.

Alignment with the Affordable Care Act
- Increased access to preventive and primary health care
- Emphasis on care coordination and patient engagement in self management to improve health outcomes
- Streamlined care management through effective use of health technology
Resource Re-Investment and Sustainability

Alignment with the Maryland Medicare Waiver
• Cost savings due to:
  – Reduced avoidable emergency department visits and unnecessary hospitalizations
  – Shorter lengths of stay and reduced re-admissions

Alignment with Community Health Needs
• Improved population health with less need for high cost interventions
• Educated and empowered consumers will make better health care choices
• Greater emphasis on addressing social determinants of health: livable communities, affordable housing, adequate nutrition, education, recreation and economic development
Accomplishments to Date

• Completed strategic plan
• Developed asset map showing health, social services, and other community resources in Long Branch
• Obtained funding from the Health Initiative Foundation for coordination and community engagement activities
• Obtained funding through the Capital Connector Entity to provide outreach and health insurance literacy education in the community
• Continuing efforts to obtain core funding for place-based initiatives to improve health that are based on community needs and linked to community resources
Maryland ASO Integration 2015

Presented by: Karl W Steinkraus

Developed by: Zereana Jess-Huff, Ph.D.

CEO, VO, Maryland

12/10/2014
Presentation Objectives

- Educate Maryland residents on changes expected to transform the mental health and substance-related disorder (SRD) systems
- Identify resources for integration process in MD
New Terminology

- “Behavioral Health” includes substance-related disorders, addictive disorders, and mental disorders
- “Behavioral health care” includes prevention, screening, early intervention, treatment, recovery support, wraparound, and rehabilitation services for persons with substance-related disorders, addictive disorders, or mental disorders, or a combination of these
- 1/1/2015 - Public Behavioral Health System
Integrated Care: Background and Context
Background and Context for Integration in MD

- July 2011 Sec. Sharfstein calls for a workgroup to explore options of integrated care in Maryland announces plans to merge the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA)
- September-November 2011 Public Stakeholder Meetings
- August 2012 MADC Position Paper on 3 models of Integrated Care
- October 2012 recommendation made to Sec. Sharfstein by workgroup to pursue a specialty behavioral health carve-out with performance risk for both providers and ASO
DHMH Behavioral Health Regulations Workgroup puts forward a proposal for regulatory reform that requires treatment providers be accredited by a State-approved accrediting entity by July 1, 2015.

January-April 2013 Maryland general assembly work paving the way for Integration

June 2013 announcement of ASO Integration timeline

June-July 2013 Stakeholder Meetings

July 2013-August 2013 Continuity of Care Workgroups

September-November 2013 Stakeholder Integration Meetings for pending Request For Proposal (RFP)

February 2014 RFP sent out to request bids for ASO
ASO Timeline

- Implementation phase-starting now
- ASO contract starts January 1, 2015
- Medicaid SRD services managed by ASO January 1, 2015
- Uninsured SRD services (grant-funded) managed by ASO for data collection (replaces current SMART system)
A New Era Emerges

- As of January 1, 2015, ValueOptions® Maryland will become the Administrative Service Organization (ASO) for the Maryland Public Behavioral Health System which will include both mental health as well as substance-related disorder services for the Maryland Medicaid population.
Administration Services Organization

- ValueOptions® Maryland
- 3 year contract (1/1/2015-12/31/2018) plus 2-option years
- Management of Mental Health and Substance-Related Disorder Services (SRD) for Maryland Medicaid Recipients and eligible uninsured individuals
Integrated Care Model
Medicaid and Substance-Related Disorders: Then and Now

- Prior to Affordable Care Act (ACA) most state Medicaid programs did not cover childless adults and only covered a limited number of parents.
- SRD services were traditionally an optional Medicaid benefit.
- Many states had very limited substance-related disorder coverage.
- 25 states plus DC are expanding Medicaid in 2014.
- Collectively will cover 5 million adults with incomes up to 133 percent of the federal poverty level (FPL).
Impact of New Populations

- ACA brings new beneficiaries including childless adults and newly eligible parents
- In Maryland, the Maryland Women’s Coalition reports as of 10-8-14:
  - 376,850 had gained Medicaid coverage as of Sept, 29
  - 89,091 had enrolled in QHPs as of Sept. 20
  - 262,979 is the net increase in Medicaid in MD since Dec. 31, 2013
Benefits of Carve-Out Model

- Reduced administrative burden to providers
- Single point of contact for entities outside of MA interfacing with Medical (Qualified Health Plans, schools, social service entities, and criminal justice system)
- Expertise in treatment of SMI and SRD
- Expertise in provider network development (includes recruitment and training)
- Specialized reporting capabilities
- Dedicated team of trained and experienced MH and SRD professionals
Carve Out Challenges to Address

- To address the issue of integrated care DHMH and VO are working in partnership on a number of innovative and integrative tools (these tools include an interactive case management system, an MCO/Physician consult line, and new coordination of care protocols)
Benefits of Maryland System

- Providers will work with 1 organization rather than multiple MCOs
- DHMH determines how the benefits are administered
- One pharmacy formulary
- SRD pharmacy will be carved out managed by Medicaid pharmacy
- ValueOptions will assist the Department with any reporting needs for pharmacy
ValueOptions® Maryland: Integration Plans

- Shared MH and SRD data across MCO/ASO (pending DHMH/legal approval)
- SRD Providers will be able to access all MA pharmacy data through our ProviderConnect Platform
- MCO/Physician Consult Line
- Clinical Coordination (HIU/VSP)
- Spectrum Application
- PCP Toolkit
ValueOptions® Specialized Trainings

- Alcohol Prevention and Screening during Pregnancy
- Promoting early detection and screening of Alcohol used by Youths
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Suicide Risk Assessment and Alternative Care Training
Covered Services for Substance-Related Disorders in the Public Behavioral Health System
SRD benefits are broken down into categories:

1. Medicaid and Medicaid Eligible Services (MA Funded)
2. Uninsured Medicaid Eligible Services (MA/Grant Funded)
3. Residential Services (Grant/State Funded)
4. Recovery Services (Grant/State Funded)
Phase I

- Begins January 1, 2015-June 30, 2015
- Includes authorization, data submission, and claims payment for all Medicaid SRD Services for **Medicaid and Medicaid Eligible Uninsured**
- Data collection and claims submission (approved claims show as zero pay) are required of all Uninsured MA Eligible Services, Residential Services, and Recovery Services
Phase II

- Begins July 1, 2015-Forward
- Includes same activities in Phase I. Continued review is being done at the State level to review funding processes
- Authorization and claims payment for Residential and Recovery services will continue to file information for data collection through ValueOptions, but will be paid through BHA/LAA service/contracts
COMAR Regulations for SUD

- COMAR regulations 10.09.80 Community-Based Substance Use Disorder Services (most recent version 9/11/2014)

- Additional regulations worth review:
  - 10.09.59 Specialty Mental Health Services
  - 10.09.45 Mental Health Case Management: Care Coordination for Adults
  - 10.09.90 Mental Health Case Management: Care Coordination for Children and Youth
  - 10.09.89 1915(i) Intensive Behavioral Health Services for Children, Youth, and Families
  - 10.09.33 Health Homes
For additional questions, please email ValueOptions Maryland at:

- marylandproviderrelations@valueoptions.com
- Karl.steinkraus@valueoptions.com
- Donna.shipp@valueoptions.com
- Sharon.jones@valueoptions.com
News You Can Use:

- FAQ are released by DHMH (BHA and Office of Health Services) who release answers on a weekly to bi-weekly basis.
- This information and a training schedule can be found at (available at http://Maryland.valueoptions.com).
Resources

- ValueOptions initial provider training for ASO implementation 10/30/2014.
Resources (cont.)

- MADC presentation: *Behavioral Health Integration in Maryland*. Dr. Gayle Jordan-Randolph. September 2014
- MADC presentation: *Behavioral Health Integration in Maryland*. Dr. Lisa Hadley. September 2014
- FAQ Issue Version #1 ValueOptions/DHMH.
The Changing Face of Health Care:
Policy Briefing for Montgomery County Leaders

Wheaton, MD
December 10, 2014

Yanique Redwood, PhD, MPH
President & CEO
The Consumer Health Foundation
Prevalence of diabetes in 2010, adults 20-79 years
Diagnosed Diabetes, Age Adjusted Rate (per 100), Adults - Total, 2012

Disclaimer: This is a user-generated report. The findings and conclusions are those of the user and do not necessarily represent the views of the CDC.

www.cdc.gov/diabetes

National Center for Chronic Disease Prevention and Health Promotion
Division of Diabetes Translation
What Makes Us Healthy

What Makes Us Healthy
- Genetics 20%
- Environment 20%
- Healthy Behaviors 50%
- Access to Care 10%

What We Spend On Being Healthy
- Medical Services 88%
- Healthy Behaviors 4%
- Other 8%

Source: Bipartisan Policy Center
WWW.BIPARTISANPOLICY.ORG
Our Vision

We envision a region and a nation in which everyone has an equal opportunity to live a healthy and dignified life. By “everyone,” we mean all people regardless of race, ethnicity, immigration status, gender identity, sexual orientation, disability, age, education or income.