Eric C. Strain, M.D.

I am writing in response to the October 31 draft and then the follow up December 5 consultant's report regarding the integration of mental health and substance abuse services for the state of Maryland. The state's interest in removing barriers to care and simplifying the availability of services for patients who suffer from mental health and substance abuse disorders is greatly appreciated, and the integration of this care is highly consistent with national trends and data that show the value that can occur when all aspects of medical care are provided for the whole person through a coordinated system.

The current discussions in Maryland appear to be addressing two concurrent and related topics integration as reflected in regulations, and integration as reflected in Medicaid funding. The purpose of this letter is to briefly address the first (regulatory integration – as it is a topic that noted in the October 31 draft), but to primarily address the second (Medicaid funding integration – as it is the main focus of the December 5 report).

Regulatory integration of mental health and substance abuse has broad implications for the treatment provider system, given that there are providers who may treat non-Medicaid patients with substance use disorders (and these providers will be impacted by the proposed changes in regulations regardless of the Medicaid deliberations). The merging of the mental health and substance abuse regulatory systems is a welcome step forward, and it is hoped that the final regulatory product will be a simplified system for providers and one that does not unduly distinguish between the mental health and substance abuse treatment of patients.

As the state moves forward in this area, a guiding principle should be simplification of regulatory processes for providers and programs. The state should utilize accreditation and licensure/certification rather than regulations as the means for ensuring that programs and providers meet standards of care. Licensure and certification should work toward the goal that providers are able to treat all patients (those who present with a substance use disorder, those who present with a mental health disorder, and those who present with both). This may require careful consideration regarding current training standards (which can differ markedly for mental health versus substance abuse providers), and there may be a need for tangible investment in workforce education. The state should take the lead on sponsoring training efforts for providers who have not traditionally provided mental health and/or substance abuse services. Primary care providers should be given targeted training for the treatment of all mental health/substance abuse disorders. Traditional mental health providers should be given training in substance abuse treatment, and substance abuse treatment providers should be given training in mental health treatment. Especially for current substance abuse providers, there should be a period of time and support to allow this group to broaden their skills to encompass mental health treatment.
Medicaid integration of mental health and substance abuse

The implications for integration of Medicaid funding for mental health and substance abuse treatment are also substantial. The present system, in which mental health funding is carved out, has produced a system that currently can incentivize fragmented care. It is also a system that can encourage the over diagnosis of primary mental health disorders versus substance use disorders, leading to inappropriate care and the loss of credibility of mental health diagnoses. Finally, the system is not well designed for coordination of treatments for patients with mental health, substance abuse, and other medical disorders. Treating patients should focus upon the "whole person." A system which perpetuates fragmentation through different funding streams for different medical disorders (mental health, substance abuse, somatic care) is ultimately a system that perpetuates silos of services and inefficiencies. Integration should occur at the service level of care, and funding should incentivize this integration. Option 1 in the December 5 consultant's report is a funding model that would be more consistent with an integration of care across all domains, and is preferred over option 2.

Reimbursement should encourage outpatient settings over higher cost inpatient settings. Outpatient reimbursement rates should reflect a reasonable cost for care, and should not encourage minimal services for patients – either as limits in the number of service encounters, or in the intensity of service provided. Reimbursement should also permit the use of primary care providers as the first line treatment setting for less complicated patients with mental health and/or substance use disorders. However, it is also important to note that there is a critical role for the specialty mental health and substance abuse treatment systems. These systems are necessary, especially for more complicated patients. The specialty mental health and substance abuse treatment systems should be incentivized to provide on-site, integrated primary health care services. Within all systems (primary care, traditionally mental health focused, traditionally substance abuse focused), funding or comparable intensities of treatment (e.g., a group therapy session) should be the same regardless of whether the patient has a mental health or substance use disorder. There should be no differential payment for a primary substance abuse versus primary mental health disorder, when a patient receives the same intensity of service.

There should be recognition that reimbursement for persons with concurrent mental health and substance abuse problems should be greater than payments for a person with only a mental health problem or only a substance abuse problem. The system of care should recognize that more complicated patients with multiple disorders are often in need of more services and potentially more specialized services (and higher payment models), especially early in the course of stabilization for their mental health and/or substance abuse problems. There is a vital need for the reimbursement system to allow for differential acuity of patients, and to provide higher levels of payment for patients with higher levels of acuity. Similarly, the system should also recognize and allow for treatments at lower levels of service (and lower costs) in cases where a patient has been stabilized – for example, in a continuing care model utilizing a primary care practice that treats patients with a lower level of acuity.

Finally, the total amount of dollars devoted to mental health and substance abuse treatment should not be reduced as a part of this integration.

Final point - It is important to note that the mental health/substance abuse treatment system should consist of a variety of services, both with respect to intensity and modality, and that ideally there is a matching between the service and the needs of the patient. Within that range of services, substantial treatment for both mental health and substance use may be able to occur through the primary care system. However, there is also a critical role for hospital-based outpatient services. These services have historically played an important role in treating complicated patients and maintaining patients – those with a mental health disorder, those with a substance abuse disorder, and those with both – in outpatient treatment. These programs are an important piece of the continuum of services. They deliver care to some of the most vulnerable and difficult to treat populations, and are uniquely suited to provide a variety of services and professionals that can address all aspects of a patient's needs. Moving forward, our system of care should continue to include more intensive services (such as intensive outpatient care), more specialized services (such as methadone treatment), and on-going services that help to maintain stability in the community (such as psychosocial rehabilitation programs). This range of services, especially in integrated programs such as those provided in hospital-based settings, is vital for the care of patients. It would be extremely unfortunate for patients if the integration of care resulted in the loss of such valuable services that maintain functioning for many patients – especially those with severe mental health and/or substance use disorders.

I appreciate the opportunity to provide this input into the State's deliberations regarding the integration of mental health and substance abuse services. This has the potential to be an important step in the care of persons in the state of Maryland, and I look forward to the continued deliberations and decisions.

Eric C. Strain, M.D.
Professor, Johns Hopkins University School of Medicine
Director, Johns Hopkins Center for Substance Abuse Treatment and Research