To: Behavioral Health Integration Workgroups

From: Nancy Rosen-Cohen, Executive Director
Ann Ciekot, for NCADD-Maryland

Date: August 15, 2012

Re: Comments on Integration

Following up on a comment made by an NCADD-Maryland representative at a recent Workgroup meeting, these comments are offered to assist the process of determining which option for behavioral health integration is best for Maryland. These are recommendations for changes that are essential if Option 1 is selected. This is not an endorsement of Option 1, these are factors to be weighed in the consideration of the options.

As the Department knows, NCADD-Maryland has been involved since the beginning of HealthChoice in seeking improvements to access to addiction treatment services provided through the HeatlhChoice managed care organizations (MCOs) and to the outcomes. If integrated behavioral health services are to be provided through the MCOs, the following must be addressed in order to accomplish several goals, including reducing administrative resources providers devote to doing business with MCOs in order to invest more state and federal dollars into direct services. These are listed in no particular order.

1) All MCOs must utilize electronic billing systems. It is unfathomable that in this technological age, with the advancement of electronic health records, that there is still at least one MCO that does not conduct its billing functions electronically. This needlessly increases administrative resources that could better be used for direct treatment.

2) MCOs must conduct their authorization processes electronically. In the mental health system, the Administrative Services Organization (ASO) does its authorizations electronically. Private insurance carriers do their authorizations electronically. Conducting business this way is much more efficient, taking fewer administrative hours to complete, creating a record that is easily accessed for verification, appeal or auditing purposes, and saving other resources such a paper and the cost of fax machines as this is the current system of verification. This system is archaic and expensive, again requiring administrative resources that could be better used for direct treatment.

3) MCOs must authorize the lowest levels of treatment in greater amounts. The mental health system ASO and private insurance carriers approve most outpatient levels of care in larger amounts, reducing the amount of administrative resources spent requesting

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frequent re-authorizations. Most private carriers do not even require pre-authorization for traditional outpatient treatment. Frequent re-authorization requirements of lower levels of care create barriers, not good clinical care. An examination of best practices among insurance carriers, public and private, could inform new procedures.

4) Behavioral health providers must only be responsible for verifying a person's medical assistance eligibility in order to provide services, such as is the process in the current mental health system. Addiction treatment providers currently continually check with which MCO the client is enrolled. Reimbursement for services can be difficult when a person changes MCOs. When a person receiving services is eligible for medical assistance, the provider should be reimbursed by the appropriate MCO without delay.

5) The existing self-referral protocol utilized in the addiction treatment system must be expanded to include access to the various levels of mental health services. One of the hallmarks of the current public mental health system is the access individuals in need have to care. If mental health services were transferred to MCOs, a process similar to that the Department undertook about 10 years ago to develop the self-referral protocol would have to take place with mental health and addiction treatment providers and advocates and the MCOs.

6) There also needs to be a re-examination of how disputes are resolved. There have been concerns and problems over the years with the existing process, especially in regards to higher levels of care. Given the experience of addiction treatment providers, a different kind of system will be required if all mental health services are also provided through MCOs.

7) MCOs must be held accountable for certain outcomes. Contracts between the State and MCOs should include specific outcome measures related to access to addiction treatment and mental health services and to the screening of Medicaid/PAC enrollees by primary care providers.

8) The contracting process each MCO utilizes must be made transparent. Addiction treatment providers have a history of difficulty obtaining contracts with MCOs. Making available to the public the process by which a provider can seek a contract – not just a contact name and number – is essential to ensure broad and comprehensive networks of qualified providers throughout the state.

Thank you for your consideration. We are happy to answer any questions.