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MADC Response to Draft Report
Recommending an Integration Model for Medicaid-Financed Behavioral Health Services

The Maryland Addictions Directors Council (MADC) appreciates the opportunity to participate in the process developed by the Department of Health and Mental Hygiene (DHMH) in the adoption of a new model to integrate funding mechanisms for public behavioral health services. As noted in our previous submissions, MADC supports a fully integrated, person-centered public behavioral health system that integrates general medical health care and behavioral health care at the point of service, relies on the clinical judgment of substance use disorder professionals and advances measurable improvement in health outcomes. MADC's ultimate goal is to design a system that supports comprehensive, clinically appropriate, integrated care for every Maryland citizen. As such, MADC stated that we could support Model 1 provided that adequate protections and accountability were ensured as delineated in the *MADC Consensus Statement Regarding DHMH Behavioral Health Finance Integration Models* submitted to DHMH on September 3, 2012.

On September 10, 2012, DHMH issued a draft report for presentation on September 13, 2012 recommending a risk-based, Medicaid funded behavioral health carve-out to be managed by a single behavioral health organization (BHO). **MADC continues to maintain that a fully integrated system with adequate protections (Model 1) would best meet the goals of integration. However, if the recommended model were to be adopted, the following concerns will need to be addressed:**

- **DHMH will need to clearly articulate the mechanisms used to ensure smooth coordination of somatic and behavioral health for all patients regardless of type of coverage.** As referenced in the DHMH draft report, The State of Michigan has developed a "care bridge" program that is designed to support coordination of behavioral health and somatic services. This program is very new and is being implemented as a result of the challenges that Michigan consumers and providers have experienced as a result of a carved-out system. Michigan program directors have emphasized that this program provides some assistance in coordination of services, but does not ensure integration of services.

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Substance Use Disorder providers have been part of the HealthChoice system in Maryland and are currently able to work with a patient's managed care organization (MCO) to ensure that their health needs are taken care of. In a carved-out system, there would need to be support for providers to assist with coordination and communication with the eleven different MCOs and the fee-for-service system that will be providing somatic health services. Without special provisions, there will be little motivation for MCOs to communicate with behavioral health providers. The carve-out presumes that the MCOs will only communicate with the singular BHO that will cover behavioral health needs for the entire State. The gap in communication between the behavioral health providers and the MCOs that cover somatic care creates a barrier to coordinated services. The provider is much more able to communicate a person's health needs to the managed care organization than another managed care organization.

- **DHMH will need to provide support to providers for true integration of services for all patients, not just those enrolled in health homes.** A carved-out system presents major challenges to providing for truly integrated care. The Substance Abuse and Mental Health Services Administration (SAMHSA) has clearly supported integrated treatment as a best practice. We applaud DHMHs support of health homes for a subset of individuals with serious illnesses or chronic health needs. However, all patients have multiple health needs that should be addressed to support best outcomes. Individuals with substance use disorders often have numerous physical health challenges and many typically receive health services through hospital emergency departments which is neither integrated, nor cost efficient. Providers who are developing innovative programs that provide true integration, including co-locating services, providing on site primary care practitioners and utilizing a multidisciplinary team approach will face billing challenges in a carved-out system. If a practice is not designated as a "health home", they will be required to bill under two systems and may be refused reimbursement unless DHMH develops policies and obtains the necessary waivers to address these concerns. Any program that implements integration into their practice should not face barriers.

- **DHMH must require that services provided in the behavioral health carve-out are in parity with benefits provided in the Medicaid HealthChoice and Medicaid fee for service system regarding medical and surgical benefits.**

Legal analysis of the Mental Health Parity and Addiction Equity Act of 2008 by the Drug Policy Clinic of the University of Maryland Francis King Carey School of Law entitled, *The Application of the Mental Health Parity and Addiction Equity Act to A Medicaid Carve-Out for Substance Abuse Services* concludes that:

> *MHPAEA would not apply to the delivery of substance abuse treatment under Maryland's existing carve-out model. Accordingly, if the State moves forward with a carve-out of substance abuse services, it will remove protections that now require substance abuse benefits to be on par with medical/surgical benefits. The State could independently impose parity requirements for substance abuse services that are provided under a carve-out, as the MHPAEA does not preempt State standards that provide greater protection or more expansive benefits than that provided under the federal law. Any State extension of parity protections to carved-out benefits must be included in statute to ensure enforcement.*[i]

This issue is particularly concerning to the substance use disorder advocate community because substance use disorder services have been historically stigmatized even within behavioral health. It was only after the 2008 Parity Act was implemented that substance use disorder services were covered as part of the MCO managed Medicaid Primary Care program waiver. When behavioral health financing is a carved-out program, behavioral health services are not required to be compared to medical services. Under the current administration, consumers of Medicaid funded mental health services have enjoyed a very rich benefit. However, without the protection of mental health parity, these benefits could be lost under future less friendly administrations.

- **DHMH must require that substance use disorder services are reimbursed at the same rate as comparable mental health services.** Substance use disorder services have been undervalued even as compared to mental health services. Providers report that comparable services provided for mental health disorders are reimbursed at higher rates than services provided for substance use disorders. Parity principles should apply not only in comparing behavioral health to medical and surgical benefits, but in comparing mental health and substance use disorder services.

- **DHMH must provide incentives in the HealthChoice and fee-for-service Medicaid system to ensure that behavioral health screening and prevention services are provided.** By choosing a carved-out system, the State has missed an opportunity to ensure that screening, prevention and early intervention for behavioral health conditions are regularly implemented at the primary care level.

Since the general MCOs are not responsible for the managing the costs of behavioral health conditions, there is little incentive to provide less costly preventative services. Without special provisions, MCOs have no incentive to pay for any services that take more time for the doctor and does not help their bottom line. Since MCOs do not pay for the more costly behavioral health services, MCOs have no financial reason to encourage screening and early intervention. Incentives should be included in the MCO contracts to ensure primary care practitioners provide behavioral health screening, prevention and early intervention.

- **DHMH must implement a payment system that allows for seamless coordination between non-Medicaid covered behavioral health services and payment for services for individuals in need who are not eligible for Medicaid services.** The charge from Secretary Sharfstein to DHMH was to "choose a specific financing model and develop detailed implementation plan" to develop a system of integrated care for individuals with behavioral health needs.[ii] The draft report is limited to addressing the structure of the Medicaid program. Public behavioral health services that are not paid for through the Medicaid program have not been addressed. Even with full implementation of the Affordable Care Act, there will remain individuals in need of public behavioral health services who are not covered by Medicaid. There are also necessary services that are not covered by Medicaid including residential treatment. It is imperative that these services are financed in a way that supports integration of all care.

  An individual may have some services that are covered by Medicaid and others that are not. Providers need a way to bill these services without administrative challenges. There are also services currently provided through grant funding that do not lend themselves to billing rates. Under the current system, these non-Medicaid services are being administered through the Alcohol and Drug Abuse Administration (ADAA), the county health departments, quasi-public jurisdictional entities, Core Service Agencies (CSAs), the Administrative Services Organization (ASO) and the Mental Hygiene Administration. As the administrations merge, these payment mechanisms must be streamlined. A payment system should be developed that facilitates seamless coordination with the Medicaid system and reduces administrative burdens on consumers and providers.

- **DHMH must ensure that public behavioral health services can be tailored to local needs.** Currently, many of the publicly funded services for substance use disorders and mental health are managed at a local level through various entities.

Although there is a recognized need to streamline the funding mechanisms, there is also an appreciation for the ability to tailor services to the needs of local communities. For grant funded services, funding mechanisms should be consolidated in a way that provides support to local priorities and needs.

The proposed Medicaid financed system recommends one BHO to manage all Medicaid behavioral health claims. The rationale is that this will reduce the administrative burden on community providers. In Michigan, different health plans are available in different regions of the State. In order to facilitate tailored services while supporting the reduction of the administrative burdens for providers in dealing with multiple BHOs, the state may consider allowing various BHOs to exclusively cover specific areas of the state. Under this modification, there would need to be a mechanism to bridge coverage for individuals who move to different parts of the state or use providers out of their home region. The advantage of allowing for more than one BHO is that there would be some competition within the system. If a BHO was not doing a good job, there would be other organizations that have experience in Maryland that could fill a gap. Competition from region to region will also spur BHOs to be more innovative in the types of programs that they cover.

- **DMHM must ensure that provider networks are open and adequate to meet the behavioral health needs of the community.** In Maryland, an estimated 414,000 people, representing every segment of our society, are currently addicted to alcohol or other drugs and are in need of treatment and support services and only one in ten receive the treatment they need.[iii] Nationwide, one and four adults and one in ten children live with a diagnosable mental illness and one in seventeen live with a serious mental illness including such as schizophrenia, major depression or bipolar disorder.[iv] As eligibility for Medicaid expands there is an increased need for providers. We need to support consumer choice and access to services by allowing all qualified providers to be a part of the BHOs network. The State has standards for certifying providers and credentialing and licensing professionals to ensure quality. As long as these standards are met, the State should not create further barriers to treatment by limiting networks. Our providers have reported that private insurance and Medicare programs routinely limit networks resulting in consumers delaying or neglecting treatment for substance use disorders. In these cases, closed networks are not based on a concern for quality, but operate as a backdoor way of denying services. This practice cannot be endorsed for Medicaid recipients.

In addition to the above discussion, MADC recommends that the key mechanisms for inclusion listed on the MADC Consensus Statement be incorporated and adapted to fit the Model adopted by the State.[v]

The following are key mechanisms for inclusion adapted to fit Model 2:

- Clear guidelines regarding how behavioral health dollars will be protected. A formula should be developed with stakeholder input to ensure that a base amount of behavioral health dollars will be protected. The formula should take into account recent utilization data and should be updated annually;
- ASAM criteria, as required by Maryland law, must be followed and the clinical judgment of the treating behavioral health professional must be utilized in determining the necessary level of care for each individual served;
- All employees involved in approval of behavioral health services must receive special training focused on behavioral health services;
- Specific billing and other data collection requirements and specific timeframes for sharing data with the Department of Health and Mental Hygiene (DHMH), providers and the general public;
- A stated commitment to compliance with Mental Health Parity and Addiction Equity Act;
- Written denials of payment for services must provide clear guidance to individual consumers and providers regarding appeal procedures and rights;
- A requirement that the BHO accept any willing provider that is legally qualified to provide behavioral health services in Maryland in order to ensure network adequacy;
- A on-line and regularly up-dated elist of providers qualified to provide behavioral health services;
- Maintenance and expansion of the current self-referral protocol for substance use disorder services to ensure consumer choice and encourage community treatment;
- Provisions to ensure adequate provider rates for all behavioral health services;
- A requirement that the BHO use billing and data collection systems that can share data with the State system;
- A requirement that the BHO use standard forms to reduce administrative burdens on providers and consumers; and
- A requirement that the BHO demonstrate the ability to handle customer service concerns for both consumers and providers.

Further, the Benefit Management recommendations included in the MADC position paper entitled, *"MADC Response to Behavioral Health Integration. A Closer Look at Three Models"* should be incorporated into the State contract. [vi]

- The State should collaborate with plans, payers, and providers to improve consumer engagement, retention and clinical/quality of life outcomes and monitor results regularly, making performance measures public.

- The Medicaid managed BHO should ensure that benefits, providers and UM practices support the treatment of co-occurring mental health and substance use disorders, ensuring continuity and coordination of care.

- The Plan should cover Screening, Brief Intervention, and Referral to Treatment *(SBIRT)* in emergency rooms and primary care settings.

- The State should ensure that after-hours access to crisis services – both telephonic and facility-based - is appropriate.

- Medication Assisted Treatment must be recognized as highly effective treatment for persons with opiate addictions. The BHO should fully and adequately cover medication as well as other necessary therapy to ensure full recovery for these individuals.

- Plan member communications should include language specific to behavioral health benefits *(Mental Health and Substance Use Disorder)* and should clearly explain how Substance Use Disorder emergencies can be handled on weekends and holidays as well as after-hours.

- The Medicaid managed BHO should allow for an appropriate range of licensed and certified professionals and safety net providers trained or experienced in substance use disorder prevention, assessment, evaluation, and treatment services.

- The State and the Medicaid managed BHO should enable the design and development of a clinical model for the coordination and collaboration of Substance Use Disorder treatment providers, Mental Health providers and primary care providers. Measure and analysis of outcomes and performance can – in time – inform the integration of funding and reimbursement in an equitable fashion.

- The State and the Medicaid managed BHO should allow reimbursement of counseling, coordination, and consultation procedure codes to enable the appropriate array of professionals including primary care physicians to provide primary substance abuse treatment services in collaboration with Substance Use Disorder professionals.

- The State and the Medicaid managed BHO should allow reimbursement for individual and group counseling, risk factor reduction interventions and family counseling for children and adolescents who are at-risk of Substance Use Disorder.

- The State should form a collaborative work group to coordinate a consumer education campaign that is culturally relevant and specific to the needs of Substance Use Disorder.

- The State should measure access, quality, patient satisfaction, and costs associated with substance use disorder. The Healthcare Effectiveness Data and Information Set *(HEDIS)* is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service which can be used to measure the performance of substance use disorder services. The Agency for Health Research and Quality or AHRQ has developed the Experience of Care and Health Outcomes or ECHO Survey for managed behavioral healthcare.

- A Substance Use Disorder Provider Advisory Panel / Member Advisory Panel should be established to review benefit designs, provider panel access and quality, medical necessity guidelines, policies and accreditation standards.

In addition to necessary contractual requirements for the BHO, DHMH will need to take the following action:

- Specify how the management of non-Medicaid services, including recovery services and residential services, will be managed. If the BHO is charged with managing some or all of these services, clear guidelines should be developed with stakeholder input.

- Apply for the necessary waivers and federal funds to leverage resources and maximize the benefits of a fully integrated program.

- Fully implement the health homes that have been funded and seek additional waivers to expand behavioral health homes statewide.

If you have any questions, please do not hesitate to contact us. Our members are eager to stay engaged as the next phase of the process unfolds.

[i] The Application of the Mental Health Parity and Addiction Equity Act to A Medicaid Carve-Out for Substance Abuse Services, p. 1.
[ii] Recommending an Integration Model for Medicaid-Financed Behavioral Health Services, Appendix I.
[iii] Urgent Problem of Addiction in Baltimore and Maryland, OSI Fact Sheet (2011); State Estimates of Substance Use from the 2007-2008 National Survey of Drug Use and Health.
[iv] NAMI Mental Illness Facts and Numbers; NIMH: The numbers count—Mental disorders in America, www.nimh.nih.gov/publicat/numbers.cfm
[v] MADC Consensus Document regarding DHMH Behavioral Health Finance Integration Models submitted to DHMH on September 3, 2012.
[vi] MADC Response to Behavioral Health Integration. A Closer Look at Three Models submitted to DHMH on August 17, 2012.