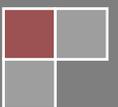


2012

MADC Position Paper

Response to Behavioral Health Integration: A Closer Look at Three Models



Introduction

The Maryland Addictions Directors Council (MADC) is an association of professionals who are specialists within the behavioral health profession who provide prevention, intervention, treatment, recovery, support and wellness services for people with substance use, co-occurring and process addiction disorders.

Position: We have participated in the evolving discussions regarding the integration of mental health, substance use disorder treatment, and general medical health care and have examined the three benefit management models presented by the State for consideration and comment. Further, we have reached out to colleagues in each of the model states to learn more about the practical functionality of their respective finance models and how effective they believe their state has been at achieving integration and improving outcomes for their citizens. Our colleagues and fellow state leaders have consistently emphasized the need for a system that is flexible and implemented in incremental stages. **We believe the best way to achieve the State's goals is to design a health care delivery model for Medicaid that integrates general medical health care and behavioral health care at the point of service. Fully integrated, person-centered care must remain the highest priority.** The Substance Abuse and Mental Health Services Administration (SAMHSA) states that,

Integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly.

SAMHSA further notes on its integration webpage that states and jurisdictions need to engage in systems integration in order to promote integrated treatment. System integration includes developing new mechanisms for addressing financing, regulations and policies, program design, inter-program collaboration, clinical "best practice" development, clinician licensure, competency, information systems, data collection and outcome evaluation. Addressing the macro financing issues is the first step in a much larger effort to implement health care integration throughout the system.

The implementation of the Affordable Care Act (ACA), of which Maryland is at the forefront, demands that all health care systems - at all levels - transform practices to ensure better outcomes and improved care. **MADC is committed to supporting this change and engaging in new and innovative solutions to ensuring improved and integrated behavioral health care, while promoting the availability of clinically sound services in an area of health care that has been historically misunderstood and poorly funded. We embrace systems change that supports better health outcomes and recognizes that maintaining the status quo is not an option.**

It is our hope that the information contained within this document will provide greater behavioral health considerations to inform the State's final recommendation. We will be convening our members and other partners upon the presentation of the workgroups' final reports. This will allow us to further review the important work completed by the workgroups and consider it in the context of our model review process. It is our intention to explore reaching consensus on a model that will best serve the citizens of Maryland. It is likely that our recommendation will not fall completely in line with the models currently under consideration, but rather may consist of a combination of models. We believe that flexibility will be an important element in determining the best model, or mix of models that will support alternative approaches and meet the diverse needs communities. By promoting flexibility, the State will be best able to leverage the current capacity and strengths in our systems and ensure the new system promotes future goals. You will see some of our thoughts surrounding such a possibility as we outline how Model 1 and 3 could possible work together. We hope the State will be open to such a recommendation. Our members will make a decision regarding final recommendations as the process unfolds.

Substance Use Disorder Specialty: We urge the State to develop a behavioral health care finance model that ensures:

- long-term recognition of substance use disorders as unique and chronic in nature;
- specialized care management protocols; and
- a treatment community of trained specialists working in tandem with their mental health and primary care colleagues.

It is imperative that decisions regarding appropriate levels of care be made by qualified, substance use disorder treatment professionals. In COMAR 10.47.02, the Maryland Alcohol and Drug Abuse Administration (*ADAA*) has adopted the American Society of Addiction Medicine (*ASAM*) Patient Placement Criteria in determining levels of care. These criteria are the most widely accepted, scientifically validated and comprehensive set of guidelines for placement, continued stay and discharge of patients with addictive disorders and are mandated in over 30 states and by several international health authorities.

The levels of care established by *ASAM*, and recognized by the state of Maryland, dictate that decisions are made by substance use disorder professionals. **Any model that is adopted must incorporate *ASAM* standards into its protocol and the State must contractually require that these standards are followed.** Likewise, the *ASAM* standards must be incorporated into the mental health levels of care to provide effective therapeutic treatment for those individuals with co-occurring substance use and mental health disorders. This will ensure that best practices are followed and clinical judgment is used in determining the levels of care necessary to treat a substance use disorder condition.

Guiding Principles

- Substance use disorders are chronic conditions and are highly treatable requiring long-term treatment support and services should be delivered in the same fashion an asthma sufferer, diabetic or COPD sufferer receives care. The Mental Health Parity and Addiction Equity Act of 2008 must be fully implemented among Medicaid managed care plans per Federal Law to ensure this level of fairness and equity.
- Evaluating and determining the need for any Substance Use Disorder treatment service should be informed primarily by the clinical need.
- Treatment costs should be known, understood, and monitored by consumers, providers, and managed care organizations as a quality improvement process that is built into the system design.
- Substance Use Disorder services should be provided in the most cost-effective and efficient manner possible and take place at the most appropriate level of care for an appropriate amount of time, consistent with *ASAM* criteria.
- Treatment should be person-centered and consider the consumer's resources, family and home environment, severity of the disorder, and any co-morbid or co-occurring medical or mental health problems.
- The behavioral health benefits managers and medical management professionals must work in coordination with each other.
- Managed care staff, involved in the management of Substance Use Disorders, should have sufficient training and experience including at least one of the following certifications or licensures as behavioralists:
 - state certification or state licensure in the Substance Use Disorder profession;
 - national certification as addiction counselors;
 - certification as addictions registered nurses ;
 - certified by *ASAM* in Addiction Medicine;
 - certified by the American Board of Psychiatry and Neurology, *ABPN*, in addiction psychiatry;
 - certified by the American Osteopathic Academy of Addiction Medicine.
- Substance Use Disorder treatment, in accordance with Institute of Medicine (*IOM*) principles, should be safe, effective, timely, equitable and the patient or consumer should be viewed and respected as the source of control.

- Substance Use Disorder benefits and treatment should promote self and peer management and recovery.
- Lastly, Substance Use Disorder and other co-occurring disorder treatment coverage should assure that:
 - (a) Timely and appropriate access to care is available;
 - (b) The quantity, location, and specialty distribution of health care providers is adequate; and
 - (c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

Issues Specific to the Management of Substance Use Disorders

In order to contextualize our recommendations from a solution-focused standpoint, MADC would like to take this opportunity to discuss some of the potential and actual concerns that confront Substance Use Disorder treatment no matter in which direction the State proceeds. The pressing issues in the dynamic between Substance Use Disorder treatment and benefits management or managed care practices include:

- Successful recovery requires wide-ranging, community-based support or wrap-around services such as sober housing, case management, family counseling and peer support. *How will these services be arranged and to what extent will they be covered by commercial Medicaid managed care plans?*
- Access to Substance Use Disorder treatment is notoriously difficult in the commercial insurance market. Access to qualified services can be made possible by allowing providers like State Certified Alcohol and Drug Counselors to join networks and panels. *How will it be ensured that such networks will be in place and how will the State address workforce development issues that will align to promote access?*
- Managing benefits and managing care assist the Substance Use Disorder patient by authorizing the right treatment, at the right level of care, for the right length of time – all of which assumes an understanding that Substance Use Disorder is a chronic condition requiring acute stabilization and lengthy community-based intervention, evidence-based practices and integrated treatment plans. Benefit managers and their medical management tools (medical necessity criteria), as well as, their business processes have the potential to unnecessarily limit access to effective treatment. Without specific direction from State regulators, Medicaid managed care plans have historically limited access and authorizations to necessary treatment and services. *How will the State ensure that provider networks are sufficient and that all clinically appropriate services are covered by MCOs?*
- Managed care organizations often develop their own Substance Use Disorder medical necessity, level of care and continuing stay guidelines. Failure to leverage and adhere to nationally validated, reliable, and accepted guidelines such as the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC) produces less than desirable outcomes. Although Maryland requires ASAM criteria to be utilized by managed care organizations, MCOs have persisted in utilizing different standards unless challenged by providers or the state. This requirement needs to be clearly stated in any managed care contract and there must be consequences for MCOs who do not consistently use these standards. *How will the State ensure that MCO's use ASAM criteria in managing substance use disorder services?*
- Many typical managed care utilization reviewers and case managers—regardless of their education and licensure—have received insufficient training and experience in the treatment of Substance Use Disorder. This leads to decisions and actions based on what people were trained for and their prevailing view of the patient and treatment systems. Nurses tend to view Substance Use Disorder through a medical detox filter and mental health professionals tend to view Substance Use Disorder through a mental health prism. *How is the State going to assure that Substance Use Disorders are reviewed by a behavioralist who is trained to meet these needs, not only through credentials but also through a new employee orientation?*

- Serial re-authorization of benefits every three to five days for a chronic condition leads to unnecessary burdens and cost inefficiencies for patients, payers and providers, and interferes with continuity of care. We would argue that these, and other very common managed care practices and strategies (particularly in the use of differential non-quantitative treatment limitations for somatic versus behavioral disorders), have been imposed much less frequently on medical specialists treating diabetes and heart disease than on those treating Substance Use Disorder and diabetes and heart disease conditions.

An assertion by an MCO that they will not treat differentially is meaningless in the absence of a public protocol backed by penalties for noncompliance imposed on the MCO. *How will the State assure parity and equity in the ways Substance Use Disorder is managed throughout episodes of treatment?*

Review of State Proposed Models

In the following section, we provide a review each of the models outlined in *Behavioral Health Integration: A Closer Look at Three Models* document presented by Chuck Milligan on July 20, 2012.

Model 1: Protected Carve-In (Tennessee)

Overview and Related Questions

This model includes behavioral health services as part of a Medicaid managed care system, and incorporates protections to ensure that funding for behavioral health services are protected. Behavioral health dollars are separated out and monitored in order to ensure “protection”. An integrated approach has shown improvement for those who chronically over utilized the Emergency Departments in Tennessee. Many of these citizens have serious mental illnesses, substance use disorders and pain management issues. An integrated MCO system is able to link physical health consequences with behavioral health problems and services can be managed in a truly integrated fashion.

1. In this model the “protection” terms must be clearly defined. *How can there be an at-risk system and protected dollars? Are the behavioral health dollars included in the MCO’s at risk? How is the protection operationalized, both quantitatively and qualitatively, and over what period of time?*
2. Behavioral health and somatic clinical services must be co-located. *Will there be limitations on where the co-located services can exist ie: only at primary care/ medical /surgical sites?*
3. Tennessee has a state-wide mandatory managed care as the result of an 1115 Medicaid waiver. *Is Maryland eligible and prepared to apply for a Medicaid waiver? If not, how does the State intend on implementing this program?*
4. A system that includes multiple MCOs would need to include contractual requirements to reduce redundancies and undue burdens on providers. For example, the billing and data collection requirements must be streamlined to require universal forms for all MCOs. Further, systems should support online submission of forms. This is routinely done in other fields such as education where colleges and university have now moved to a common application process. In addition, MCO’s should be required to use IT systems that communicate across platforms and collect data that is uniform, accessible and aligned with the State requirements. *What contract requirements would be required to ensure that the administrative burden related to billing and data collection are reduced?*

Recognized Strengths

- In this model, MCOs manage or administer the delivery of behavioral health services and contracts with community-based, behavioral health providers. This ensures behavioral health providers have a direct relationship with the MCO, as opposed to having a relationship mediated by a third-party such as an MBHO. Having a direct versus a mediated relationship provides strategic and operational advantages for providers.

- This model allows the cost of high-end users to be managed as a whole. Their co-occurring issues can be addressed together and there is not added back end bureaucracy of managing two systems.
- This model offers choice and competition that encourages innovation and improves quality for consumers.
- In this model, all providers of behavioral health services, whether primary or specialty care, utilize the same system eliminating billing challenges providers may face in making judgment calls related to diagnosis. The focus remains on treating the individual, regardless of the diagnosis or severity of the disorder.
- This model removes stigma and promotes substance use disorder as a chronic health condition that is treated like any other chronic health condition.
- This model supports fully integrating behavioral health and somatic health at all levels of care and promotes the implementation of preventative services at the primary care sites.
- This model promotes a more seamless transition protocol for those churning in and out of Medicaid and into the Exchange than it would be in a carved out system.
- This model supports the long-term goals of the ACA by supporting true integrated health.

This model could be combined with Model 3 that provides for a population carve-out for those with severe, behavioral health conditions. The primary model allows for integration with protections for behavioral health, while including a robust, health home system to provide integrated care for those with the most intensive, co-occurring needs.

Recognized Challenges and Concerns

- A great deal of control rests with the MCO, which may have better or worse prior experience and greater and lesser capability with and understanding of behavioral health providers and services. With multiple MCOs, this can result in inconsistent benefits to consumers. The state would need to be highly prescriptive in outlining contract requirements to ensure behavioral health competencies are set out.
- The current document does not provide sufficient detail regarding the co-location dynamics. For instance, who defines and controls the physical service location and to whose program will the overhead and space expenses accrue? In order to ensure access to services and support to the existing provider network, the State would need to provide clear guidance in the following areas:
 - The role of the State in defining and controlling co-location;
 - Details surrounding the physical location of services;
 - Details regarding the accrual of overhead, administrative and indirect costs and space expenses;
 - Billing for services requires workflow, revenue codes and business rules that are clear and agreeable to all collaborating providers; and
 - Billing rules concerning billing for multiple behavioral health and primary care services from a primary care setting on the same day must be unambiguous and supportive of co-location efforts.
- The State could be at risk of losing providers who do not have experience with billing multiple MCOs adding further strain to the system during a transition.

Model 2: Risk-Based Service Carve-Out (Connecticut & Michigan)

In these models the behavioral health benefit is carved-out of the general somatic care benefit and specialty behavioral health services are managed through an Administrative Service Organization (ASO) or a Behavioral Health Organization (BHO).

The rationale for a carved-out system is the recognition that behavioral health services are specialty services that are fundamentally different from traditional general medical health care services. This model ensures that services are properly managed by having a separate entity, with a specialty in behavioral health manage the benefit.

Connecticut

Overview and Related Questions

This model consists of a behavioral health carve-out that is administered through an ASO. The ASO would perform the administrative duties of paying for services and collecting data on behalf of the Department of Health and Mental Hygiene (DHMH). The ASO would not manage benefits in the way that an MCO does. The ASO approves services as directed by the State. ASOs provide referral and information assistance to consumers who are part of their system. This model is most similar to the current mental health carve-out. The proposed model would add performance risks to incentivize outcomes that are part of the current system. Currently in Connecticut, the entire Medicaid system utilizes ASO's and not MCOs. This makes it easier to coordinate care. Even with only a few ASOs, Connecticut reports challenges with coordination.

1. With the history of mental health services being carved-out and substance use disorder included in the primary benefit, there is a concern that substance use disorder services will not reap the benefits of a carved-out system. ***Will categories of services be excluded (such as residential) under an ASO system, even if clinically recommended? Will the ASO be required to hire staff that understand and have experience working with individuals with substance use disorders?***
2. The ASO will be charged with directing grant service funds. With the reorganization of the Department occurring at the same time, the directions from the Department could come from staff who do not have experience with substance use disorder services. ***How will decisions regarding grant funding be determined in this system?***
3. Currently, Connecticut does not use managed care organizations in any part of their Medicaid system. The general health benefits are also administered by an ASO. This allows for easier coordination that is not comparable when using a combined ASO and MCO model. ***Would the state consider a model that provides for an ASO to manage all the general health benefits? How will the state improve coordination between the multiple MCOs and the ASO to support integrated services?***

Recognized Strengths

- Under the option presented as the Connecticut model, there is potential for behavioral health services to be delivered by an experienced ASO vendor, leaving risk at the state level, and incorporating performance risk for providers. Our providers would be better able to manage performance risk than care provision risk. With reasonable performance targets and good quality processes operations, providers will earn bonuses.
- Currently in Connecticut providers are not at risk, although they do have performance incentives for some providers. The ASO is only at risk for their profit margin for which they need to meet or exceed yearly performance targets. This model encourages high-quality, without cutting services or putting providers at risk.
- Statewide ASO organizations and companies are familiar with and are a knowledgeable part of the behavioral health industry. As managers of the administrative process and compensated for these processes, they tend to be less invested in care cost reductions than at-risk MCOs or MBHOs. However, it is important to review the incentives in the ASO's contract with the state Medicaid agency to insure that they are being compensated more significantly for quality improvement rather than for cost reduction.
- A statewide ASO will be better equipped to collect data using one system. This data is useful for billing, as well as, ensuring quality care and measuring and reporting outcomes.

- As this model is very similar to the current mental health carve-out, the current ASO should not have as many administrative hurdles in adding substance use disorder services to its plan. This may limit some of the usual challenges faced when new management organizations assume their role.

Recognized Challenges and Concerns

- Poorly conceived contracts between ASOs and state Medicaid agencies can negatively impact providers. Particularly troublesome are provider rate cuts at the initiation of new ASO contract agreements or highly burdensome administrative practices that have been discredited.
- ASO's centralize the collection of data. Initially, this can be an administrative burden for providers new to the system. An ASO model is less likely to address cost and efficiency concerns that managed care organizations are designed to address.
- In Maryland, an ASO will have to interact with the multiple HealthChoice MCOs for somatic care. This could be a bureaucratic burden and present challenges in sharing data and supporting integrated care.
- A carved-out financing system is not a truly integrated system from the top down. SAMHSA recognizes that integrated systems promote integrated treatment. In a carved-out system, full integration of services is challenging.
- The proposed options assume that the larger Maryland HealthChoice program will remain. The challenge will be ensuring that substance use disorder services are understood by the ASO.

Michigan

Overview and Related Questions

In Michigan the state contracts with specialty prepaid health plans (PHP) that cover designated areas. The state implementation guide states,

Specialty PHPs must assume an important role in the protection of vulnerable populations and in securing full participation, integration and inclusion for these individuals. In short, specialty PHPs have responsibilities for ensuring freedom, opportunities for achievement, equity and participation that go far beyond the usual and customary obligations of a managed care entity. Linking the larger purposes of the managed care program to the qualification requirements for specialty PHPs means that attention must be directed not only to standard managed care administrative capabilities, but also to the organizational characteristics, the public policy performance and the regulatory competencies of the applicant entities. Specialty PHPs must be value-based, policy oriented, community-focused, administratively capable and resource-conscious organizations operating in the public interest.

This is a risk based model that puts a strong emphasis on the behavioral health competencies of the organization charged with managing the behavioral health care. The risk is assumed by multiple regional entities that contract with private and public providers to serve each region of the state. The current Michigan system does not integrate mental health and substance use disorder.

1. Maryland appears to be recommending a system that would apply the Michigan mental health carved-out system to both mental health and substance use disorder treatment. ***Is the reference to the Michigan system, based upon the Michigan mental health carve-out with an inclusion of substance use disorder services?***

2. In Michigan, there are opportunities for the PHPs to take on case management and coordinating roles. *Does the State anticipate case management and other coordinating services be undertaken by these management entities?*
3. In Michigan, the management and risk bearing is taken on by separate regional entities. *Would the State consider contracting with entities by region, rather than one or several entities that operate statewide?*
4. Michigan was selected by the Centers for Medicare and Medicaid Services (CMS) was awarded a contract for the development of an integrated care plan for dually eligible persons (Medicaid and Medicare). This population represents individuals with some of the most complex needs, yet they are currently subject to episodic and fragmented care as they navigate two programs with distinctly different rules. Michigan's proposed integrated care model covers all Medicare and Medicaid services and benefits, including inpatient, outpatient and primary care, skilled and custodial nursing facility care, behavioral health and developmental disabilities services, hospice, home health care, other community-based long term supports and services, durable medical equipment, and prescription drugs. *Will Maryland be able to access federal funds to implement this type of effort as part of its integration efforts?*

Recognized Strength

- The advantage of the Michigan model is that it is innovative and maintains the integrity of the behavioral health specialty sector while at the same time promoting integration with somatic healthcare. The model requires strong behavioral health capabilities, knowledge and values and would likely support appropriate clinical treatment and facilitate linkages to recovery supports. Similar to the Connecticut model, quality of care is a high priority. The use of a risk-based specialty behavioral health does address efficiency concerns that may be lacking in an ASO model.

Recognized Challenges and Concerns

- Individuals may churn between the MCO system and BHO system. The 20 visit outpatient limit requirement for the MCOs and potential churn between the MCO and BHO is of concern. This model may utilize large community organizations with expertise in behavioral health to provide the management of the behavioral health services. Since most of these organizations in Maryland are mental health providers or organizations, substance use disorder services are at risk of being shortchanged. This system is modeled after a state system that does not have integrated behavioral health. Therefore, it has not been tested to see if it supports integration which is the primary purpose for the change in Maryland.

As noted in the Connecticut model, the lack of fiscal integration with somatic care is not a fully integrated system. This poses challenges with integration of care. Individuals with mild to moderate mental health and substance use disorders may not be able to access the rich services available to those with more serious behavioral health challenges who are part of the carved-out system. There is a potential disincentive for individuals to access care at the primary care location because the benefits are more limited than what one can access in the carve-out.

Model 3: Population Carve-Out

Overview and Related Questions

This is a carved-out model that employs a separate ASO to cover all health and mental health services for a population of individuals with serious mental health and substance use disorders. This model lends itself to being combined with Model 1.

1. This model uses the health home model on a larger scale. Arizona was awarded, a planning grant with expanded responsibility for Title XIX eligible adults determined to have a Serious Mental Illness (SMI). This model is referred to as "Recovery through Whole Health" and is funded for and fully responsible for coordinated and integrated behavioral healthcare and physical healthcare for eligible adults with SMI through the use of Health Home Services. The model is based on the goals, principles and concepts contained in the Health Home provisions in Section 2703 of the ACA. ***Will the State be able to utilize the ACA incentives for Health Homes to implement this program?***
2. Arizona was able receive a Medicaid waiver to serve this population. ***Will the State need to apply for a Medicaid waiver to implement this model?***
3. Arizona adopted this model in one area of the State motivated, in part, by a need to respond to a lawsuit. ***Without the pressure of a lawsuit, will the State be able to access the resources needed to implement this model on statewide scale?***
4. Under this model, there would need to be clear guidelines as to who would be eligible for this carve-out and what protections would be in place for those who are not included. ***How will the State define who is eligible for the carved out services? Will there be stakeholder input into the development of eligibility guidelines?***

Recognized Strengths

- This model makes the health home concept accessible to more individuals than a few pilot projects. The idea of providing special management for the most severely ill is another way to address the increasing medical costs of individuals with severe behavioral health needs.
- By carving-out high-end, behavioral health clients, these individual's health needs can be addressed by promoting a longer, healthier life. By targeting only those who truly need special services, this smaller carved-out group, allows for an integrated plan for the rest of the population.
- If the system is designed around the most complex, high-cost, high utilizers, there will be a "no wrong door" approach. All those suffering with co-occurring disorders or either substance use disorder or a mental health disorder exclusively, will be efficiently and effectively served and attain better outcomes.

Recognized Challenges and Concerns

- This type of carve-out serves a limited population who only the most severely ill. The problem is that individuals with substance use disorders and other behavioral health needs may move in and out of this category.
- This model runs the risk of further perpetuating the stigma of designated populations and may offer challenges to those who want access services, but do not meet the guidelines.

This model could be combined with Model 1 that provides for a population carve-out for those with severe, behavioral health conditions. The primary model allows for integration with protections for behavioral health, while including a robust, health home system to provide integrated care for those with the most intensive, co-occurring needs.

Benefit Management Recommendations

- The State of Maryland 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 of Maryland 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.
- 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 State of Maryland should ensure that after-hours access to crisis services – both telephonic and facility-based - is appropriate.
- 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.
- Medicaid managed care plans 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.
- Plans should cover Screening, Brief Intervention, and Referral to Treatment (SBIRT) in emergency rooms and primary care settings.
- 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.
- Medicaid managed care plans 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 its managed care partners 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 its managed care partners 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 its managed care partners 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.

Conclusion

We appreciate there are certainly strengths and challenges to each model the State is considering. **Our primary concern is to ensure that substance use disorder services are adequately funded and that the clinical judgment of substance use disorder professionals is utilized in the management of care.** It is essential that ASAM criteria be maintained in law and enforced by contract with all managed care organizations. Further, services for substance use disorders, mental health and general medical health care must be fully integrated at the point of service. Regardless of the funding mechanisms, there should be incentives to ensure that best practices and systems are in place to allow for the continuous collection and sharing of data.

It will be imperative in the next phase of this process to adequately address how we merge an integrated delivery system with integrated services at the clinical level. Our members stand ready to actively engage in that process as their expertise will be an important and valuable contribution. The professional community is eager to continue partnering in the design of a new system that overcomes the detrimental consequences our current fragmented system promotes. **MADC's ultimate goal is to design a system that supports comprehensive, clinically appropriate, integrated care for every Maryland citizen.**



The Maryland Addictions Directors Council

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