To: Joshua Sharfstein, M.D., Secretary, Department of Health and Mental Hygiene
Renata Henry, Deputy Secretary, Behavioral Health and Disabilities

From: Nancy Rosen-Cohen, Ph.D., Executive Director
National Council on Alcoholism and Drug Dependence, Maryland Chapter

Date: December 8, 2011

Re: Public Comment on Behavioral Health Integration

These comments are submitted in response to the report from consultants entitled "Future Options for Integrated Behavioral Healthcare." NCADD-Maryland would like to make several comments about the content of the report and express its desire to see a process developed for the next steps in this systems change that is inclusive and transparent.

The report leaves many questions unanswered. It is unclear what the original charge was to the consultants when this process began at least one year ago, so perhaps they were not asked to make recommendations on the level of detail still needed. While it is evident the consultants have a good deal of knowledge about models of behavioral health care delivery, the options recommended do not address several key issues, including how to combine the existing fee structures, how to address the separate eligibility criteria in the two systems, and how to reconcile the differing certification and licensure requirements of the workforce.

Further, there are many details still needed about how this new system would function and impact both consumers and providers. One immediate question is whether or not it is envisioned that the self-referral procedures would remain in place. NCADD-Maryland believes strongly that a self-referral mechanism must be built into the new system from the start to ensure access. People seeking treatment for alcohol and drug addictions need to have access as immediately as possible and into a system with no wrong door, even if referral to a different provider or level of care is required after a short engagement, as happens now.

Another priority concern of NCADD-Maryland is the continued requirement that ASAM Placement Criteria be used by both providers and payers in determining the level of care for a consumer. The report seems to indicate that such a mechanism is desirable, but it is unclear. The only way to ensure that consumers are entering an appropriate level of care, and that providers will be reimbursed for services, is to require a uniform determination system.

There are many other issues dealing with the specifics about how a new system would work that need to be addressed. NCADD-Maryland urges the Department of Health and Mental Hygiene to develop a process that is inclusive, transparent and creates a realistic timeline to make decisions and implement changes. We have seen a great deal of inclusive and transparent

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activities in the past few months regarding major issues being addressed in the Medicaid division. Plans have been created for the deliberation of issues such as selective contracting and long-term care that have spelled out timelines, brought stakeholders to the table to engage in meaningful discussions, held public hearings around the state, and provided realistic time periods for comments to substantive documents, all done in an effort to give everyone interested ample opportunity to participate in the decision making process.

It is also imperative that these discussions on the behavioral health system include representatives from the Medicaid division of DHMH. A great deal of the assumptions made in the integration report relies on changes in Medicaid, including selective contracting. Efforts must be made to closely coordinate changes in the behavioral health system with changes in Medicaid and implementation of health care reform.

NCADD-Maryland believes there is a misperception that advocates and others in the field are resistant to change. On the contrary, consumers want changes that make accessing appropriate services easier. Providers want changes that relieve the administrative burdens of multiple systems regulations and allow them to focus on clinical services. Advocates want changes that ensure a full continuum of care is available to everyone, regardless of insurance status.

NCADD-Maryland remains standing ready to engage in meaningful discussions with state agency representatives, facilitate the engagement of the recovery community, and support changes that are developed with the input of all stakeholders.

National Council on Alcoholism and Drug Dependence - Maryland (NCADD-MD)

NCADD-MD RLP conducted a focus group of men and women in recovery to get individual feedback on the Maryland Department of Health and Mental Hygiene plan to establish an integrated behavioral healthcare system, under the Affordable Care Act. Participants were asked for feedback regarding health service delivery, financing and benefits management, and were asked to discuss the present systems strengths and weaknesses, and ideas for improvement to provide affordable, accessible and comprehensive service delivery for every Marylander.

Important elements of a DHMH Integrated System, recommended by people in recovery, include:

- Care of the whole person in one comprehensive system of health care service is the most efficient for adequate delivery of mental health and substance use disorder services.
- An Integrated System must take into account the health care needs of diverse populations, and should be able to deliver services to traditionally underserved groups, who previously have had a difficult time obtaining services for co-occurring disorders.
- All services should be subject to standardized quality control and outcome goals, no matter who the state selects to be service providers.
- Communications between somatic and behavioral health providers should take place and be consistent among providers.
- Primary care doctors should use screening and prevention services.
- Medication assistance for mental health and addiction problems should be available to all clients based on an individual assessment.
- Clients should have the ability to maintain their provider even if insurance changes.
- The patient should have the ability and clearance to self-refer into substance use disorder treatment, and delivery of service should be immediate.
- Behavioral health benefits should be provided with parity to medical and surgical benefits.
- Residential care should continue to be offered at the current levels available, despite cost considerations. Consumers felt that residential treatment should be longer than the basic 28-day intervals, and should be reviewed on a case by case basis.

Overall, an integrated system should be capable of providing outpatient and intensive outpatient services, case management/community support, recovery./health coaching, medication assisted treatment and crisis response for individuals with either mental health and or substance use disorders, including individuals with co-occurring disorders and those with serious mental illness or serious emotional disturbance. Of course, from the recovery consumers standpoint, especially those that receive services

under PAC/Medicaid, consumers who participated in our forum were completely unconcerned with whether services would be delivered under Managed Care Organizations(MCO) or a fee for service system, or if Medicaid contracts with an Administrative Service Organization (ASO) or a Third Party Administrator (TPA).