



December 8, 2011

Renata Henry  
Deputy Secretary  
Department of Health and Mental Hygiene  
201 West Preston Street  
Baltimore, Maryland 21201

**Re: Future Options for Integrated Behavioral Healthcare**

Dear Secretary Henry:

Thank you for the opportunity to provide comments on the December 5, 2011 report, Future Options for Integrated Behavioral Healthcare (hereafter Future Options). The report provides an important assessment of the current delivery system for publicly funded substance use disorder and mental health services and begins to chart the course for the integration of the financing and delivery of these health care services. We appreciate the background information provided on other state models and the consultants' consideration of stakeholders' views.

The report provides a strong basis for the adoption of Option 1, although many questions must be answered before a final endorsement of any model is possible. The following addresses certain assumptions in the report, sets out our immediate questions and identifies the key points with which we agree. We urge the Department to establish a timeline and workplan for addressing the many issues that must be resolved for integration to occur in sync with the implementation of the Affordable Care Act in 2014.

**I. Underlying Assumptions**

**A. Profile of Persons Obtaining Health Care Through the Public Substance Use Disorder and Mental Health Systems**

The report states that its recommendations are based on what is known about Medicaid beneficiaries who use the public behavioral health system, but it references national studies rather than Maryland specific data. (Future Options at 25) We agree that the new delivery system should be developed to serve the unique profile of Maryland's citizens who suffer from these disorders.

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Has the Department developed data that accurately describes this population, the level of co-occurring mental health and substance use disorders as well as other health care conditions, and the severity of their conditions?

This would seem essential to understand the scope of services that will be needed and the settings in which those services can be delivered most effectively. The data could reveal that certain populations with chronic conditions require a different delivery or financing model that is built into a managed care delivery system.

### **B. Delivery of Substance Use Disorder Care Through the Primary Care System**

The report states that “[a]s is now true, primary care will continue to provide the majority of behavioral health treatment” (Future Options at 22), and it sets out a vision of primary care screening for behavioral health conditions, treating depression, anxiety and other mild/moderate conditions, and linking patients to specialty providers. We share this vision for the future. At the same time, we are concerned that the report does not accurately reflect the current state of primary care practices for screening and intervention for substance use disorders, referring to specialty care or providing medication-based treatment. While much work is being done, we are not aware of any evidence nationwide or in Maryland that supports the conclusion that primary care is playing this critically important role in the substance use disorder context.

Establishing an accurate base-line assessment of primary care practice in Maryland is essential because that will determine what must be done to ensure primary care is a real partner in the identification and treatment of substance use disorders. Strong State leadership is required to advance the primary care community’s involvement in treating substance use disorders. We have been disappointed, for example, that the Maryland Health Care Commission has not required SBIRT for alcohol or drug use in the State’s medical home pilot, even though national standards would require such inclusion. The State’s PCMH pilot would be a logical starting point to demonstrate best practices (and indeed the integration report notes that the primary care practices that are participating in the medical home pilot are the right partners for a chronic care medical home pilot). (Future Options at 22). We urge the Department to lead an effort with the primary care community to make this a reality.

### **C. Level of Care Determinations for Substance Use Disorders**

The report suggests that MCOs do not currently employ a system to make specific level of care determinations for substance use disorder service authorizations. (Future Options at 24 and 27 – recommending that MCOs and ASOs propose and receive State approval for a level of care determination system). We are troubled by this assertion (and recommendation) because Medicaid regulations make clear that MCOs must follow the ASAM-PPC when making levels of care authorization determinations. COMAR 10.97.67.10(A)(1)(b); 10.09.67.28(I)(2); and 10.09.80.03. To the extent this recommendation reflects that MCOs are not following the law,

that violation must be addressed immediately. Substance use disorder providers have, indeed, reported variability in MCO compliance with the ASAM placement criteria.

Second, the report recommends that a single level of care determination system be adopted for both substance use disorder and mental health care. We are concerned that this recommendation may not reflect the best clinical practice and seems to assume little differentiation between mental health and substance use disorders. We would urge that the appropriate system or systems for making level of care determinations be based on solid clinical standards. Under Maryland law, substance use providers have been required to follow the ASAM-PPC criteria for all grant and Medicaid reimbursed services, and any departure from that standard must be evidence-based and fully justified. In addition, standards for level of care determinations under Medicaid managed care plans are non-quantitative treatment limitations under the Mental Health Parity and Addiction Equity Act. The standards that are selected must be comparable to the care determination standards used for medical/surgical care.

## **II. Questions Related to Recommendations**

### **A. Single Entity Managing Public Behavioral Health Benefit**

The report recommends that the same entity manage all components of the public behavioral health benefit. (Future Options at 23). This recommendation seems to address, in part, the fragmentation in purchasing and financing of services. (Future Options at 24). As a preliminary matter, more data is needed to evaluate whether substance use disorder services for the insured and uninsured are fragmented. Care levels are largely the same under the grant funded and Medicaid systems and providers of those services overlap, particularly after the PAC expansion.

If this recommendation were operationalized under Option 1, Medicaid MCOs would manage both the federal and state grant and Medicaid dollars. This raises a number of questions. First, how would the system address access to substance use disorder care, which is largely a self-referral system? The report critiques the self-referral system as a barrier to the MCOs ability to manage the substance use disorder benefit (Future Options at 24), but that system was instituted in 2001 to address the sharp decline in persons accessing addiction treatment under a managed care system. We are concerned that history could repeat itself if the self-referral system is dismantled and MCOs are permitted to limit their network panels. While it is important to coordinate somatic care with substance use disorder care, coordination can be achieved without the elimination of the self-referral system. A "no-wrong door" approach to care means that patients can enter the health care system through a trusted addiction treatment program or community-based organization and then be linked to general health care services. In addition, given the concern that there may be insufficient substance use treatment providers to meet the need for care after the 2014 expansion, it is critically important that individuals be able to seek

treatment without delay and with providers who are most accessible and appropriate for that individual.

Second, the report provides no guidance on how substance use disorder and mental health federal and state grant funds would be managed under such a system. We seek guidance on how grant dollars would be apportioned among the MCOs; and how federal Substance Abuse Treatment and Prevention funds and state grant dollars currently devoted to addiction services would be preserved for those persons and services not covered under Medicaid rather than absorbed for mental health care for uninsured persons.

Third, the report does not address the role of local health departments and core service agencies under this proposal. What, if any, role would these entities play in the planning and/or oversight of services and the coordination of an individual's care?

### **B. Delivery Platform -- Community Behavioral Health Organization**

The report defines a community behavioral health organization as one that is capable of serving all persons with mental health and substance use disorders, including persons with co-occurring disorders and serious mental illness or emotional disturbance. (Future Options at 21 and 23). While this model is sound, it seems to require a business model that some providers may not want to adopt or will be unable to achieve without significant assistance. In our view, the standards that are adopted should not penalize these programs, and the State should work to enhance program capacity to move to a more comprehensive level of services either through direct delivery or development of business partnerships.

We also question whether the proposed model places a heavier burden on behavioral health providers to "do it all" than is expected of other health care practices that focus on an area of expertise and provide linkages for other required services. It is important that the report reflect the view that one size does not fit all and that integration should promote and support a wide array of integration models including affiliations and stand alone substance use treatment programs when and where such models meet the health needs of the population. Certain individuals may never be reached by traditional health care models but will access care if certain critical services are provided through trusted organizations in their own communities. In addition, as demonstrated by the Baltimore Capitation Project, some individuals with serious mental illness and/or substance use disorders and other chronic health care conditions may be best served through a stand-alone model that addresses all health needs.

### **III. Endorsement of Specific Recommendations**

#### **A. Data Collection and Reporting**

We agree that robust data collection and reporting requirements be established through contract requirements and/or regulation. Substantial data will be needed to formulate the scope of services as well as the capitated rates. The report identifies metrics, and we request that the Department reconvene the data committee, composed of state officials, organizations with expertise in Medicaid data analysis, and public stakeholders, that had met in 2009 to identify the appropriate data points.

#### **B. Behavioral Health Benefit Package**

We agree that a behavioral health benefit package should be identified and should, at a minimum, provide for the full range of services currently funded under the state's Medicaid and grant funded systems. The essential health benefit design under the ACA will require a mental health and substance use disorder benefit to be defined by evidence-based standards. The Department of Health and Mental Hygiene must take an active role in ensuring that the behavioral health benefit is based on such evidence-based, nationally recognized standards for all such services provided in the public health program. We recommend that the ASAM PPC and the National Quality Forum National Voluntary Standards for the Treatment of Substance Use Conditions serve as the guide for the appropriate substance abuse disorder services. In addition, the benefit must also comply with the Mental Health Parity and Addiction Equity Act, insofar as the scope of services must be comparable to that in the medical/surgical benefit.

#### **C. Institute Performance Standards**

We agree that performance standards should be included in Medicaid contracts as soon as possible, either through the State's proposed selective contracting process or separately. The report does not appear to recommend specific standards, identify the entity that will monitor and enforce the standards or suggest the penalty for failure to meet those standards. These issues must be addressed. Among the performance standards identified in the report that other states seem to have adopted are: indicators of key clinical process (SBIRT), access to care (penetration rates), measures of collaborative treatment (communications between somatic and BH); reductions in rate of inpatient psychiatric admissions, improved "fill rates" for psychiatric medications, decreased state hospital stays; functional status of patients.

#### **D. Health Home Requirement**

We agree that the MCOs and ASO should be contractually required to develop a health home for persons with chronic addiction and mental health disorders. In addition, we recommend that

other primary health home models include performance measures and incentives for primary care physicians to perform screening and brief intervention and to coordinate care for substance use disorder treatment.

#### **IV. Time Frame for Developing and Enacting Integration Model**

The report does not set out the time line for developing the integration model or the key players who have responsibility for moving the initiative forward. This effort will require a high degree of coordination between the ADAA, MHA and Medicaid. In addition, the State must also work to improve the primary health care system's capacity and commitment to achieve the recommended level of primary and behavioral health care coordination. We urge the Department to develop a work plan and to include provider and consumer stakeholders in the process.

Thank you for considering our views. We look forward to working with the Department as it moves forward.

Sincerely,



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