Anne Arundel County Department of Health

Thank you for the opportunity to comment on the draft behavioral health integration report.

We are concerned that the consultant's draft report seems to be recommending a direction that would support an integrated care model for mental health and SUD which would be most appropriate to a large private practice setting or an FQHC type of structure. For those local health departments like ours that provide direct clinical services for both mental health and substance abuse treatment, it is not clear what role local health departments would have under this type of structure, unless we were to partner with an FQHC or we would restructure our operations to become an FQHC look-alike. It is also interesting to note (page 9 of report) that HRSA's Bureau of Primary Care would be funding the cost of FQHC's to become NCQA recognized. This raises the question as to what, if any, financial support local health departments will receive from the Federal or State level to gain required certifications/recognitions to provide services, which will most likely be incorporated into future Federal/State grant requirements.

From a clinical services and public policy perspective, it appears that the consultant's draft report does not address how and what kind of balance there will be under an integrated system as far as equitably funding mental health and SUD services. While the implication is that patients will be given comprehensive treatment for co-occurring disorders in an integrated care model, we have concerns that funding for mental health services may be given priority over SUD services, especially given the fact that sufficient staff with SUD training and expertise may not be available to provide treatment in an integrated care model. While the issue of workforce development is beyond the scope of the consultant's report, the increased numbers of new patients entering an integrated public system may prove to be overwhelming to the limited number of providers in Maryland.

In an integrated practice model, there will also be issues concerning licensure and scope of practice. Maryland's current licensure system for health care professionals does not lend itself to cooperative adjudication of issues related to overlap in scope of practice (Secretary Sharfstein indicated at the last HCRCC meeting that he will be asking for legislation to address these issues.).

Cost containment is another significant concern, and it appears the answer from the consultant is to obtain this goal by selective contracting. The disadvantage to selective contracting is that it would clearly place control of the market in the hands of the state's largest insurance providers, and would not necessarily guarantee improvements in the quality of care.

Maryland is a unique given that the state has considerable power to regulate the both the insurance industry (Maryland Insurance Commission) and health care providers (Maryland Health Care Commission and Maryland Health Care Cost Review Commission). While a review of best practices from other states is certainly helpful, the consultant does not address if or how these practices could be implemented in Maryland given our regulatory environment.