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To: Behavioral Health Integration Workgroups  
From: Pat Stabile, Chair  
Tracy Schulden, Vice-Chair  
Date: August 20, 2012  
Re: Comments on Integration

The Baltimore City Substance Abuse Directorate (Directorate) wishes to provide comment on the options presented for behavioral health integration. Directorate members believe that eventually, Maryland should have a fully integrated system. But given the current problems in the HealthChoice system with the managed care organizations and the current processes in place, we cannot support that option. And without more details about how a carved out system would work, we are not comfortable supporting that option as well.

The directorate shares the same concerns expressed by NCADD. They are listed below.

- 1) All MCOs must utilize electronic billing systems. Paper is a thing of the past and cost more than an electronic transmission.
- 2) All MCOs must conduct their authorization processes electronically. In the mental health system, the Administrative Services Organization (ASO) does its authorizations electronically. Private insurance carriers do their authorizations electronically or via phone which is a more efficient method. The current practice of faxing a two page authorization request/notification, waiting for the response, contacting the MCO when no response is received, retaining the authorization for verification or appeals is costly and outdated.
- 3) MCOs must authorize the lowest levels of treatment in greater amounts. The mental health system ASO and private insurance carriers approve most outpatient levels of care in larger amounts and many private insurance carriers have eliminated authorizations for standard outpatient services, reducing the amount of administrative resources spent requesting frequent re-authorizations. Frequent authorizations increase the cost of providing the service.
- 4) Behavioral health providers must only be responsible for verifying a person's medical assistance eligibility in order to provide services, such as is the process in the current mental health system. Addiction treatment providers currently continually check with which MCO the client is enrolled. Reimbursement for services can be difficult when a person changes MCOs. When a person receiving services is eligible for medical assistance, the provider should be reimbursed by the appropriate MCO without delay.
- 5) The existing self-referral protocol utilized in the addiction treatment system must be expanded to include access to the various levels of mental health services. One of the hallmarks of the current public mental health system is the access individuals in need have to care. If mental health services were transferred to MCOs, a process similar to that the Department undertook about 10 years ago to develop the self-referral protocol would have to take place with mental health and addiction treatment providers and advocates and the MCOs.

- 6) There also needs to be a re-examination of how disputes are resolved. There have been concerns and problems over the years with the existing process, especially in regards to higher levels of care. Given the experience of addiction treatment providers, a different kind of system will be required if all mental health services are also provided through MCOs.
- 7) MCOs must be held accountable for certain outcomes. Contracts between the State and MCOs should include specific outcome measures related to access to addiction treatment and mental health services and to the screening of Medicaid/PAC enrollees by primary care providers.
- 8) The contracting process each MCO utilizes must be made transparent. Addiction treatment providers have a history of difficulty obtaining contracts with MCOs. Making available to the public the process by which a provider can seek a contract – not just a contact name and number – is essential to ensure broad and comprehensive networks of qualified providers throughout the state.

Thank you for your consideration.

Presented by,

Tracy Schulden, LCSW-C  
Vice-Chair