December 8, 2011

Joshua M. Sharfstein, M.D.
Department of Health and Mental Hygiene
Office of the Secretary
201 West Preston Street, 5th Floor
Baltimore, MD 21201-2301

Re: Comments on Future Options For Behavioral Healthcare Report

Dear Secretary Sharfstein:

We appreciate the information provided in the report, *Future Options for Integrated Behavioral Healthcare* prepared by Croze Consulting for the Maryland Department of Health and Mental Hygiene (DHMH). After careful review of the report with fellow stakeholders and our members, we would like to share what we view as important points for your consideration.

MADC supports the articulated vision “the ultimate goal is to integrate the care of the whole person in one comprehensive system of healthcare services.” We appreciate the examples given of other state systems and the recommended options for the Department to consider. However, there is a severe lack of specificity and no consideration for anticipated challenges. MADC recognizes the potential benefits in both Option 1 and Option 2. In each case, what is lacking in the report is the important detail related to implementation. Success in transforming the current system will require a detailed timeline and roadmap for in depth review of any and all proposed options.

**Specific Recommendations and Concerns**

**Behavioral Health Benefit Package**

We recommend that the singular behavioral health benefit package should include the following:

- Comprehensive benefits that offer the full continuum of care and services including prevention, early identification, outpatient and residential treatment, relapse prevention medication, and recovery support services.
- Adoption of *National Quality Forum (NQF) National Voluntary Standards for the Treatment of Substance Use 2 Conditions* to ensure that all health practitioners -- medical, mental health and addiction providers -- implement practices to identify substance use conditions, initiate treatment, and provide evidence-based care and management.
- Requirements for primary care providers and school-based programs to deliver preventive care, screen patients for substance use problems and provide brief interventions and referrals to treatment and recovery support.
- Access to appropriate treatment through adequate behavioral healthcare networks, timely authorization for treatment and management, and coordination
of care with other care providers.

- A requirement for plan outcome measurements that reflect quality behavioral health care for all related services.
- Assurances that incarcerated individuals enroll in a plan and have support services available upon re-entry to the community so that healthcare services can be delivered immediately upon discharge.
- Promotion of a broad array of developmentally specific services across all healthcare settings for adolescents and young adults.

**Delivery Platforms**

We recommend the development of a system that includes the full range program options for consumers including small programs that serve only persons with substance use disorders, programs that provide all behavioral health needs and programs that provide comprehensive health services.

The discussion on the recommended delivery platforms states that,

Maryland should begin to encourage a delivery platform that is behavioral health ‘user friendly’, creates easy access to both mental health and substance use disorder treatment, that possesses the clinical capability to treat both conditions and to provide effective consultation to the primary care or specialty medical system. (Page 21)

The challenge in Maryland is to be able to achieve the goal of integration without reducing access to services. There are a large number of small substance use disorder providers in Maryland who meet the needs of many individuals in the state. These providers do not have the clinical or structural capacity to provide comprehensive behavioral health services. They do have the capacity to make referrals and link to primary care and specialty mental health providers. Just as in the medical field there are specialists and subspecialists who treat specific disorders; there should be room for providers who specialize in substance use disorders or mental health.

In Maryland, requiring all providers to be capable of providing both mental health and substance use disorder services will pose serious challenges to access to treatment. Under the current system many substance use professionals are not credentialed to provide mental health treatment. The State is already experiencing a workforce crisis of substance use disorder professionals. Eliminating professionals and programs currently providing treatment will create a severe reduction of the availability of services.

For those providers who have the capability, MADC supports innovative integrated health programs including behavioral health homes that provide comprehensive services.

**Community Behavioral Health Organization**

We recommend that benefit plans include residential services as part of the full continuum of services provided by Community Behavioral Health Organizations.

The section discussing Community Behavioral Health Organizations does not include residential care as part of the continuum of services. This service needs to be included as an essential part of the continuum of care. Although the majority of patients do not require residential care, a small number of high need patients do. Those who do not have access to this service cycle in and out of treatment and the criminal justice system. The ASAM criteria currently utilized as the standard for determining levels of care in Maryland, includes level III residential services as a necessary component for individuals who need safe and stable living environment in order to develop their recovery skills. (MADC Fact Sheet #5)
Use of Standard Assessment Criteria
We recommend the use of ASAM criteria.

ASAM is applicable to persons with substance use disorders and those with dual diagnosis. ASAM includes all levels of care from prevention to residential care. Just as with other conditions, providers use several different tools including DSM V and ASAM is assessing a patient and determining needs. The ASAM levels reflect a spectrum of treatment options representing differences in setting, types and range of services, and intensity of service use and delivery. The goal of treatment is to provide the specific services needed by each patient, at the appropriate level of intensity, within the appropriate setting.

The intent of patient placement guidelines is to place a person in the least intensive level of care that will achieve treatment objectives without sacrificing safety or security. The ultimate goal is to improve the effectiveness of care, to ensure access to affordable care, and to support the development of cost-effective treatment systems. They support efforts to establish a common language for substance use disorder treatment, to agree on consistent placement decisions.

ASAM also includes a tool for co-occurring disorders. A system that includes objective criteria with the full continuum of care is important in a managed care system to ensure that patients can get the appropriate level of care.

Primary Care Practice
We recommend a system that incentivizes primary care providers to include screening and brief intervention for substance use and behavioral health concerns with strong referral linkages or partnerships with specialty behavioral health providers.

The section discussing primary care practice notes, “As is true now, primary care will continue to provide the majority of behavioral health treatment, especially for conditions like depression.” The report from which this is cited, Integrating Mental Health Treatment into the Patient Centered Medical Home, goes on to outline that,

Nonetheless, PCPs typically under identify mental health problems in their patients. When they do identify these conditions, PCPs more often than not deliver treatment that is suboptimal and characterized by inadequate follow-up and monitoring of patients, especially among the low-income patient population and racial and ethnic minorities.

The statement above, and the experience of providers in Maryland, challenges the assumption that there should be a preference for behavioral health to be provided by primary care providers. This paper is directed to the restructuring of the public system that serves primarily the low income and minority population referenced in the quote above.

Feedback from MADC members indicates that most primary care providers may write prescriptions, but do not provide therapy or counseling. Primary care providers have been slow to incorporate behavioral health protocols in their practices. Our recommendation would be that primary care providers increase screening and referral protocols. However, the majority of behavioral health care should be provided by a specialist. The State will need to take action to ensure that doctors are
trained and incentivized to conduct screenings and brief intervention. Specialty providers will also need training and assistance from the State in reference to integrated practices and new business models.

The system that is developed needs to include various models to address the needs of different populations in Maryland. For example, individuals with high intensity behavioral health needs may be best served in a behavioral health home model in contrast to a person with mild depression being served by a primary care provider with linkage to a professional counselor.

**Health Homes**

*We recommend the State support the development of behavioral health homes and encourage other health home models to incorporate behavioral health screening into their practice.*

Although the early part of the paper gave a number of examples of health homes, there is only mention of health homes in the primary care practice section. More attention should be given to this model which has the potential of best serving the population with intense behavioral health needs. There is also passing mention of primary care practices becoming patient centered health homes. There needs to be a commitment by the State that these types of health homes incorporate behavioral health into their practices. In our experience, there has been a resistance to requiring primary care practices to include SBIRT and other behavioral health screenings in their practice. There will need to be a concerted effort by the State to provide incentives.

**Self Referral Protocol**

*We recommend that the state maintain the ability of consumers to self-refer to substance use disorder providers.*

The critique of benefit design and management notes that the self-referral protocol interferes with the MCO management of the substance use disorder benefit. Self-referral is a very important component to the current system. Most individuals receiving substance use disorder services are self-referred. Due to the stigma still associated with substance use disorders, many people will not seek help through their primary care provider. In many communities, people go to the provider most convenient to them. Removing the ability to self-refer will reduce the number of people seeking treatment. There should be a no wrong door approach to treatment. Individuals can be referred back to their primary care provider to address their health needs. In addition, MCO’s still approve the level of care provided. There are other mechanisms that can be put in place to ensure that best practices are followed and benefits are managed efficiently while maintaining the benefits of self-referral.

**Risk Sharing**

*We recommend that risk sharing should not be a requirement in the new system.*

There is a concern that providers will be asked to share the risk in providing care. This is viewed as an incentive to better manage the care within the program. Under their current business model,
small providers will not be able to absorb the financial burden. The MCOs are designed to bear the risk. For providers who choose to participate in a health home model where risk sharing is anticipated, this should be an option.

**Purchasing and Financing**

We recommend that the Department further assess how best to manage Medicaid and other public funding sources in order to ensure fair apportionment of resources and continuity of care.

The critique of purchasing and financing concludes that the substance use disorder benefit for the uninsured is not coordinated with the Medicaid benefit and results in disconnected services. However, although the funding streams are different at the point of service, the level care is essentially the same. From the patient point of view, services may not be disconnected at all.

There are potential problems with consolidating state and Medicaid funding sources in terms of allocating resources fairly. It is noted earlier in the paper that “the public behavioral health benefit should be managed through the same entity.” (Page 20, second bullet) Currently, grant dollars are managed by the health department for substance use disorders and by the local core service agencies for mental health. Protections must be put in place to ensure that substance use disorder services currently provided by the State that are not covered by Medicaid are still available to serve that population. The report does not make clear how the funds would be apportioned if the MCOs are charged with managing grant funds. Further, there is no recommendation regarding the anticipated role of the core service agencies and health departments. A more complete analysis of the current system in each jurisdiction is required.

**Training and Technical Assistance**

We recommend that the State provide training and technical assistance to the provider community to assist in the transformation process.

There is a long list of principles/specifications that are recommended in order for Maryland to move to an integrated system. Community Behavioral Health Organizations are described as organizations that have “consultant-liaison physicians to primary and specialty medical care and have tele-health capacity.” Many of the recommendations will require providers to deliver services differently and develop new business models. Providers will need training and technical assistance to transform their delivery models. With the shortage of behavioral health professionals in the workforce, the State cannot afford to lose providers. There needs to be further attention to this matter to ensure resources and technical assistance is directed to these issues.

**Professional Boards**

We recommend that State agencies and professional boards work with public and independent providers to ensure a smooth transition as changes are implemented.

The paper notes that Community Behavioral Health Organizations will employ a mix of licensed professionals. The variety of professional board certification requirements in Maryland presents a major challenge to meeting this goal. The boards will have to come together and make changes to regulations in order to allow programs to maximize the use of professionals. Under the current system many substance use professionals are not credentialed to provide mental health treatment. The State is already experiencing a workforce crisis of substance use disorder...
professionals. It is important the boards work with professional associations to reduce barriers that exist to professionals integrated behavioral health services in all settings. Boards and professionals will need to work together to develop user friendly practices to support the development of a vibrant behavioral health professional workforce.

Data
We recommend that the Department obtain and analyze data specific to the Maryland Medicaid population.

The recommendations are based on what is known about Medicaid beneficiaries nationwide. There is no data included that is specific to the Maryland Medicaid population. It would be helpful to have data on the profile of populations in the State including the level of co-occurring disorders, persons with disabilities, persons coming from the criminal justice system, persons with mental health disorders and persons with substance use disorders.

Parity
We recommend that the State develop a mechanism to ensure behavioral health parity is enforced in the public and private systems.

Although the federal law has been in place for several years, many individuals do not know how to assert their rights under the law. Consumers need to be assured that integrated benefits are provided equal to medical and surgical benefits as required by law. The State should develop a mechanism to ensure consumers know their rights and that parity is being enforced.

Interim Steps

We recommend that selective contracting be implemented and that the department specify the performance standards that will be implemented in the interim stage.

Any action that is taken during the interim should be laying the groundwork for the full implementation in 2014. The Department needs to identify standards that will be used in the short term. Analysis of additional data is necessary in developing a final plan. Currently, there are statutory requirements on MCOs that are not enforced. There needs to be mechanisms in place to ensure that performance measures and other requirements are adhered to. Specific consequences for failure to meet standards should be determined. This could include reduction in payment, lawsuit under the contract and ability to participate in future contacts.

We recommend training for providers in developing new business models and in providing integrated care should begin as soon as possible.

Providers need to be prepared to make necessary changes by 2014. Adequate professional training will ensure that the services are broadly available by that time.
It is essential as the State moves forward to ensure that any new system will include the following elements;

- Clear contract conditions to ensure quality of care and access to services to patients throughout the state.
- Resource allocation for models that work for different populations.
- Options for behavioral health homes and other chronic care patient health homes.
- Incentives for primary care doctors to employ SBIRT and other behavioral health screening tools and linkages to specialty providers. There should not be an assumption that good behavioral health is being provided at the primary care level.
- The full continuum of care, from prevention to residential, should be available.
- One set of criteria that includes the full continuum should be employed.
- State sponsored provider training and resources.

We appreciate the opportunity to share input on the report. We hope that you will continue to refer to the MADC Ideal Treatment System as your efforts progress. Further, we strongly encourage the various workgroups and committees to reach out to the provider community to gain input throughout the next steps of the process. It is imperative that those who are working on the front lines be engaged in options under consideration. The provider community throughout our state is quite diverse and it is imperative that their varied input be considered. They know best how to serve their respective communities. We hope that you will take every opportunity to seek their valuable expertise and input to ensure that Maryland enjoys the full promise of health care reform.

Sincerely,

Tracey Myers-Preston  Lynn Albizo
Executive Director          Director of Public Affairs