STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 30, 2014

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2013 Joint Chairmen's Report (pp. 55-56) – Report on Behavioral Health Integration

Dear Chairmen Kasemeyer and Conway:

In keeping with the requirements of the 2013 Joint Chairmen's Report (pp. 55-56), enclosed is the Department's report on the implementation details of its behavioral health integration initiative. The report addresses eligibility criteria for individuals receiving behavioral health services and responds to other specific inquiries from the General Assembly. The language requesting the report withholds a $1,000,000 appropriation made for the purpose of administration pending submission of this report.

Thank you for your consideration of this information. I respectfully request that the funds withheld pending submission of this report be released. If you have any questions or need more information on this subject, please contact Christi Megna, Assistant Director of Governmental Affairs at (410) 767-6509.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Chuck Milligan
Tricia Roddy
Christi Megna

Report on Behavioral Health Integrated Service Delivery and Financing System Implementation

Submitted by
The Maryland Department of Health and Mental Hygiene

2013 Joint Chairmen's Report, p. 55-56

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Introduction

This report is submitted to comply with budget language adopted by the Maryland General Assembly. The budget language requires the Department of Health and Mental Hygiene (the Department) to provide additional information regarding its model for integrating behavioral health care for mental health, substance use and somatic services. This report addresses eligibility criteria for individuals receiving these services and responds to specific inquiries from the General Assembly. In particular, the report:

- Details how the new model aligns financial incentives, resolves adverse selection, promotes information exchange, establishes multidisciplinary care coordination teams and develops competent provider networks;

- Outlines how services to the uninsured and Medicaid-ineligible services to Medicaid recipients are provided;

- Discusses the role of existing local planning agencies and State administrative support for those agencies;

- Outlines how other existing programs that operate outside of the current Medicaid, mental health fee-for-service and substance use grant programs operate;

- Evaluates the outcome measures currently in place in the Medicaid, mental health and substance use systems and details how those measures should be improved or expanded upon;

- Discusses whether or to what extent the current array of statutorily-created substance use treatment programs should be consolidated into a single block grant;

- Evaluates current rate-setting methodologies and determines what changes to those methodologies should be made; and

- Evaluates the fiscal impact of the model.

Background

As part of the State FY 2012 budget, the Maryland General Assembly asked the Department to convene a workgroup and provide recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues." In response, the Department undertook a three-phase initiative to develop a model for an integrated behavioral health service delivery and financing system. Each phase included significant input from a diverse group of stakeholders, representing individuals with behavioral health needs, providers and advocates.[1]

Stakeholder Process: Phase 1

Phase 1 began in 2011 and involved collaborative work between the Department, a consultant and stakeholders to assess the strengths and weaknesses of Maryland's current system. Maryland's current financing and delivery model has strengths, including greatly improved access to care in recent years in each separate domain (mental health, substance use and somatic services). However, accessing care across these domains can be difficult for individuals, as they are often unable to receive coordinated care. The resulting report reached five conclusions regarding the system's weaknesses: (1) benefit design and management are poorly aligned; (2) purchasing and financing are fragmented; (3) care management is not coordinated; (4) performance and risk are lacking; and (5) integrated care needs improvement.

Stakeholder Process: Phase 2

Phase 2 began in early 2012 as the Department and stakeholders set out to develop a broad financing model to better integrate care across the service domains. A series of large public stakeholder meetings and an extended comment period informed the process and the development of the model. After reviewing the various options, a cross-disciplinary leadership steering committee within the Department recommended that Maryland adopt a performance-based carve-out model. Specifically, the Steering Committee urged the Secretary to pursue a specialty behavioral health carve-out that combines treatment for specialty mental illness and substance use disorders (SUD) under the management of a single administrative services organization (ASO) with significant and meaningful performance risk at the ASO and behavioral health provider levels.

Following extensive deliberation with interested stakeholders, including members of the General Assembly, the Secretary accepted the Steering Committee's recommendation to adopt the performance-based carve-out model. The Secretary selected this model due to its many advantages, including (1) ending a duplicative and confusing system of financing for SUD and

[1] For background reports see: http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx

mental health treatment; (2) supporting effective models of integrative care for behavioral health and medical conditions by aligning incentives and performance targets; (3) reorganizing the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) into a single administration, *i.e.*, the Behavioral Health Administration (BHA), to increase efficiency; and (4) expanding interfaces with other State systems to address public health challenges including homelessness, recidivism and educational failure.

Stakeholder Process: Phase 3

Phase 3 of the process commenced in June 2013. The Department moved forward with its decision to implement a performance-based carve-out of mental health and substance use services and to merge the MHA and the ADAA into a single administration, the BHA.

Through a series of six large public meetings, the Department continued to solicit feedback from stakeholders. Specifically, the Department sought stakeholder feedback to address issues related to the behavioral health integration model, including:

- Financial incentives;
- Mechanisms to encourage shared savings and coordination between the ASO and HealthChoice managed care organizations (MCO);
- Mechanisms for care coordination;
- Prior authorization rules;
- Quality measures and reports (performance incentives/sanctions);
- Mechanisms to address billing issues;
- Related MCO specifications;
- Data sharing; and
- Beneficiary protections.

Comments and discussions from these meetings informed the development of a Request for Proposals (RFP) as well as the design of related policy changes in the existing program for MCOs. The RFP solicits an ASO to administer the new carve-out. The Department plans to release the RFP in early 2014, with the goal of implementing the new system in January 2015.

Additional stakeholder meetings discussed particular aspects of the JCR requirements. Specifically, the Department discussed how services to the uninsured and Medicaid recipients will be provided; the role of existing local planning agencies and State administrative support for those agencies; how other existing programs that operate outside of the current Medicaid, mental health fee-for-service and substance use grant programs will operate; and how the Department will cost out the expenses associated with implementing the new behavioral integration model.

Discussion on Goals of Behavioral Health Model

The new behavioral health model focuses on implementing a performance-based carve-out of mental health and substance use services and on merging the MHA and the ADAA into the BHA. The carved out services will be managed through an ASO on a fee-for-service basis.[2] The Department plans to release the RFP in early 2014 and implement the new system in January 2015.

The goal of the new model is to provide a seamless service delivery system that protects individuals and the public while promoting timely access to services, care coordination, and wellness and recovery for all individuals—namely, those covered by Medicaid and the uninsured. It will achieve this broad-based goal by:

- **Aligning Financial Incentives**. Financial incentives and penalties for performance will be built into the new ASO contract. In a future phase, the Department plans to build financial incentives based on outcomes into provider payments, allowing providers to share in the savings if they reduce overall expenditures for care. These risk-based performance measures are based on nationally-recognized outcome measures, state-specific outcome measures, customer service metrics and provider service measures.

- **Resolving Adverse Selection**. There are a number of individuals who have co-occurring mental health and substance use conditions; in FY 2011, approximately 37,000 individuals had such a co-occurring condition. Currently, the siloed authorization system—with different entities approving mental health and ADAA services—leads to inefficiency, as providers may select the entity with greater payment rates for services. Integrating these services under one administration and a single ASO removes such incentives and the corresponding inefficiencies. In short, the new system will ensure that individuals receive services in the most appropriate setting, rather than based on perceived benefits to providers. In addition, the new ASO will ensure that duplicate payments are not made through two different systems. As with any type of service carve-out where high-cost inpatient services exist, the right incentives need to be in place to prevent cost shifting by either the ASO or the MCOs. The new model ensures that the Department will be responsible for certain medically necessary high-cost inpatient hospital services where substance use is the primary diagnosis. Such inpatient services will largely be detoxification treatments provided in beds licensed for detoxification, as opposed to beds licensed for medical or surgical care. Lastly, a clinical review team at the Department will be responsible for monitoring and reviewing claims to ensure payments are made appropriately by the correct entity.

[2] The Department does not intend to unbundle the weekly rate paid to opioid treatment programs at this time.

- **Promoting Information Exchange.** The new ASO will be authorized to receive information concerning services provided to participants with substance use and mental health treatment needs, regardless of whether the ASO pays for these services. The MHA currently uses an ASO, ValueOptions, to collect authorization and payment information, and the ADAA uses the State of Maryland Automated Record Tracking (SMART) system. Under the new model, there will no longer be two systems. Rather, the new ASO will collect both mental health and substance use information. Addiction providers will submit data to the ASO, not through the SMART system. The ASO will also receive information on payments for all behavioral health drugs. The RFP requires the ASO to use this information not only to ensure that individuals receive appropriate behavioral health services but also to coordinate with MCOs and accountable care organizations (ACOs) to facilitate information-sharing with primary care providers.[3]

- **Establishing multidisciplinary care coordination teams**. The ASO staff will have expertise in both SUD and mental health treatment. The new ASO will also be required to coordinate with core service agencies (CSAs) and local addictions authorities (LAAs) who have direct access to participants within local jurisdictions. The new ASO will collaborate with the MCOs on the referral process and work with the Department to facilitate communication between providers and the MCOs.

- **Developing competent provider networks**. Providers will be trained by the BHA to develop and enhance provider competency in the areas of SUD and mental health treatment. The Department understands that the rollout of the new ASO needs to include provider education on how to seek authorization and payment through the ASO. Drawing upon evidenced-based research, the BHA will develop and implement trainings on co-occurring disorders. These training opportunities will increase network adequacy in the field and enhance freedom of choice for participants to find providers that meet their needs. In addition, the State is moving forward with an initiative to require providers to be either independently-licensed to provide care or part of a program that is accredited by a national accreditation body.

How the Behavioral Health Model Serves Various Populations

The Department's new model for providing behavioral health services requires substance use services to be carved out of the HealthChoice managed care benefit package. Substance use and specialty mental health services for Medicaid enrollees will be reimbursed through the ASO. This includes residential treatment for children. Additionally, the ASO will be accountable for

[3] The Department understands the federal confidentiality standards for the disclosure and use of alcohol and drug treatment information (42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2) and is working with its attorneys to ensure compliance.

new performance-based incentives. Lastly, the ASO will continue to help administer the non-Medicaid covered mental health services to the uninsured. The local jurisdictions will continue to receive and administer the grants from the BHA, albeit at a lower amount because outpatient services—assessments, counseling, opioid maintenance and intensive outpatient services—will be removed from the grants. The new ASO will manage these services, which will be provided with state-only funds. Such services are covered by Medicaid, and the Department's goal is to have a single system approving and managing these services for the uninsured. The local authorities will continue to provide other non-Medicaid covered SUD services to Medicaid enrollees and the uninsured through grant awards. This includes residential services for adults as such services are not reimbursed by the federal government under the Medicaid program. The local authorities will continue to directly provide or purchase these services through grants from the BHA, *i.e.*, establish service contracts, authorize admissions and reimburse providers for these services. However, data on these services will be submitted to the ASO.

Eligibility: Medicaid

The new behavioral health model does not propose any eligibility changes to the Medicaid program beyond what is planned in 2014 based on the Affordable Care Act (ACA). Under the ACA, Medicaid eligibility will expand for adults under the age of 65 beginning January 1, 2014. The income eligibility threshold for parents will increase from 116 percent of the federal poverty level (FPL) to 138 percent of the FPL. Additionally, childless adults will be covered up to 138 percent of the FPL. Therefore, the ACA requires that individuals served under the Primary Adult Care (PAC) program receive full Medicaid benefits. The current PAC program covers only primary care visits, prescription drugs, emergency room bills, and outpatient mental health and substance use treatment. The program does not cover hospital stays or most specialty services. PAC enrollees account for approximately 88,000 of the 108,000 new enrollees projected to enroll in Medicaid during 2014.

Individuals are expected to move between Medicaid and the Maryland Health Benefit Exchange ("the Exchange") as their households move above or below the threshold of 138 percent of the FPL that divides Medicaid and Qualified Health Plans (QHPs). There are a number of Medicaid-covered services that are not covered by QHPs, such as psychiatric rehabilitation programs. The Department is aware of the need for policies to assist with this transition. The Maryland Health Progress Act (HB 228) was passed during the 2013 session. It includes continuity of care provisions under §15-140 of the Insurance Article that become effective on January 1, 2015, and it requires the Department to collaborate with the Exchange, the Maryland Insurance Administration, and the Maryland Health Care Commission to study and report on the efficacy of the provisions. The Act also obliges the Department to issue recommendations, if warranted, to increase the State's efforts to promote continuity of care. The report is due to the Governor and the General Assembly by December 1, 2017.

Eligibility: Uninsured

Currently, the ADAA and MHA have different eligibility criteria for services provided outside of the Medicaid program. Generally, these programs provide services to individuals who do not have access to other insurance and have incomes below 200 percent of the FPL. (Providing access to non-Medicaid covered services for Medicaid enrollees is an exception to the uninsured criterion.) The key difference between the two programs is that the ADAA applies a sliding fee schedule to those accessing services whereas the MHA does not. To align the delivery systems for mental health and substance use, outpatient services — assessments, counseling, opioid maintenance and intensive outpatient services — will be removed from the local grants. These services will now be authorized by the ASO. For state-only services authorized by the ASO, the Department is proposing the application of one standard behavioral health policy, which is outlined below.

- *State-Only Services Authorized by the ASO*

  The BHA will provide eligibility for services for up to three months based on medical necessity to individuals who meet all the following criteria:

  - The individual requires treatment for a behavioral health diagnosis covered by the Public Behavioral Health System (PBHS);
  - The individual is under 250 percent of the FPL, and not covered by Medicaid or other insurance;
  - The individual has a verifiable Social Security Number;
  - The individual is a Maryland resident; and
  - The individual has applied to
    - Medicaid;
    - The Exchange;
    - Social Security Insurance (SSI); or
    - Social Security Disability Insurance (SSDI) if they have an illness/disability for a period of 12 months or more (or are expected to have an illness/disability for a period of 12 months or more).

  The following will be temporary exceptions to the criteria above:

  - The individual is currently receiving SSDI for mental health reasons;
  - The individual is under 19;
  - The individual is homeless within the state of Maryland;
  - The individual was released from prison, jail, or a Department of Correction facility within the last three months;
  - The individual is pregnant;
  - The individual is an intravenous drug user;
  - The individual has HIV/AIDS;

- The individual was discharged from a Maryland-based psychiatric hospital within the last three months;
- The individual was discharged from a Maryland-based Medically-monitored Residential Treatment Facility (American Society of Addiction Medicine (ASAM) Level III.7) within the last 30 days;
- The individual is requesting services as required by a HG 8-507 order or referred by drug or probate court; or
- The individual is receiving services as required by an order of a Conditional Release.

Non-U.S. citizens who meet one of the temporary exceptions listed above would be eligible for temporary services. Additionally, Medicaid enrollees will have access to non-Medicaid covered services. If needed, providers may apply for an additional three-month authorization plan.

There will be no sliding fee schedule for individuals in the PBHS. The ASO will pay providers according to the Medicaid fee schedule, which is consistent with how state-only mental health services are paid today. This means also that the rates paid for SUD services will be comparable to the amount of funding received via grants and patient fee collections for that service collected today. Because the new rate will fully reimburse the providers for their services, the providers will not be eligible to receive patient contributions.

Many uninsured individuals will eventually become eligible for Medicaid. Federal Medicaid rules allow Medicaid coverage to be applied retroactively for up to three months prior to the month of application, provided the individual would have been eligible for coverage during the retroactive period had s/he applied at that time. If the ASO pays for services with state-only funds during a retroactive eligibility period, it will reconcile these payments to replenish state funds.

If uninsured individuals who are ineligible for services through the ASO request treatment, the treatment program has the option to serve them using a fee scale determined by the treatment program. Such fee scales will be under the auspices of the treatment program, and services would not be supplemented by State funds.

A few stakeholders expressed concern that the cost-sharing requirements under commercial plans and QHPs may be too high and will prevent individuals from accessing services, suggesting that state-only funds could be used to wrap around such requirements. At this time, the Department is restricting the use of state-only funds. The restriction covers only those who are uninsured or those behavioral health services that are not covered under Medicare, Medicaid or commercial plans, which includes QHP coverage. The Department does not want to provide an incentive for individuals to select catastrophic plans that have low monthly premiums but high cost-sharing requirements.

Additionally, the Department is aware of the relationship between the open enrollment period for QHPs and when individuals can sign up for QHPs during the year. Generally, individuals can sign up outside of the open enrollment period only if special enrollment has been triggered; for example, if the individual has lost minimum essential health coverage, or the individual gains or loses a dependent. Medicaid coverage is considered minimum essential health coverage. This means that individuals are eligible to enroll in a QHP if they lose Medicaid coverage outside of the open enrollment period. If the individual's circumstances have not changed and no special enrollment is triggered, the uninsured person must wait until the next open enrollment period to apply for QHP coverage. The Department will be taking this into consideration as it rolls out its eligibility policy, keeping a keen eye especially on working with individuals on case-by-case basis to ensure coverage.

- *State-Only Substance Use Services Not Authorized by the ASO*

  There will be no change in either the eligibility policy or the patient contribution for services—*i.e.*, residential treatment services—that continue to be administered by the locals through grants from the Department.

How Will Services be Authorized Under the New Model?

For mental health services, the current ASO—in conjunction with the MHA and the CSAs—developed processes for authorizing and paying for most services to the uninsured as well as for Medicaid-eligible and -ineligible services. These processes permit effective clinical coordination of services and maximization of resources by facilitating cross-jurisdictional service utilization. Services managed under contract by local CSAs are controlled locally, and participant-operated services are available on demand.

However, for SUD services, the approval process is currently spread across two entities—MCOs and local authorities—depending on the funding source and level of service. Generally, local authorities authorize grant-funded services, and the MCO eligibility review authorizes Medicaid-funded services. Both the MCOs and local authorities should follow the placement criteria developed by the ASAM. This means that even at the lowest ASAM placement levels, initial services require providers to notify the MCOs for authorization purposes and, if needed, reauthorization. The local authorities currently collect data on the services provided but do not necessarily use this information for authorization purposes. Therefore, three areas must be considered as changes to the behavioral health system take effect: authorization, form of payment and data collection.

Under the proposed new model, the Department's BHA will be responsible for making clinical policy decisions regarding service authorization. The ASO will make operational authorization decisions for all ambulatory (outpatient) SUD services and selected Medicaid-covered, hospital-based services (*e.g.*, detoxification). By unifying the authorization process, without regard to funding source or mechanism, the proposed model will result in more consistent care decisions and increased access to services. When consistent authorization is applied across all populations, providers will be better able to predict payment levels, and the quality of care for individuals will improve.

In 2010, the Department expanded its self-referral policy for substance use services covered by the HealthChoice benefit package. Under the policy, individuals may select their own provider for both assessment and treatment services even if the provider does not have a contract with the individual's MCO. Additionally, the policy allows for certain services to be provided without prior-authorization. Individuals can access 30 visits of any combination of individual, family or group therapy sessions without prior-authorization. However, due to the cost differential of hospital-based providers, hospital-based providers must receive a prior-authorization. See the link below for the specifics of the self-referral policy.

https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Substance%20Use%20Disorder%20Program.aspx

This self-referral policy will remain in effect until substance use services are carved out of the HealthChoice benefit package. While there will no longer be out-of-network providers once the services are carved-out and managed by an ASO, the Department understands that allowing individuals to access certain services without prior-authorization may still be required to ensure access. The Department will be reviewing and updating this self-referral policy to make sure it continues to promote access under the new model.

How Will Services Be Provided: Grant-Based or Fee-for-Service?

MHA moved away from grants some time ago and now pays for services for the uninsured on a fee-for-service basis; ADAA funded services are still provided through grants to local jurisdictions. A key advantage of carving out both SUD and mental health services is the ability to streamline a duplicative and confusing service financing system. Currently, services are reimbursed by one or more funding mechanisms: Medicaid, State General funds, Federal Block Grants or other federal, state and local grant funds. The proposed model will allow the ASO to authorize and pay for SUD services provided to Medicaid enrollees. Additionally, outpatient services provided to the uninsured will also be authorized and paid for by the ASO. These are services that would be covered under Medicaid if the individual qualified for Medicaid coverage. The ASO will pay for these services on a fee-for-service basis. Opioid treatment programs are

currently reimbursed for a bundled set of services at a weekly rate. At this time, the Department does not intend to unbundle opioid treatment services under the new behavioral health model. Non-Medicaid covered services will continue to be provided through grants to the local authorities.

How Will Clinical Data be Collected?

The MHA collects data from the current ASO, ValueOptions, and the ADAA collects data separately via the State of Maryland Automated Record Tracking (SMART) system. Under the new model, all data required for both mental health and SUD services will be submitted to the ASO. Through the registration and authorization processes, selected data elements and ensuing reports will be required by the ASO on all services delivered, regardless of funding source or payment methodology. To assure continued compliance with both federal and state reporting requirements, the indicators collected will include those currently submitted through SMART. Based on reporting requirements and previous requests, the Department is including a number of SUD service reports as a deliverable in the RFP for the new contract. The reporting requirements will be expanded as necessary, with input from local jurisdictions and providers. Table 1 illustrates the authorization, payment, and data collection mechanisms for SUD services.

Table 1: Authorization, Payment and Data Collection Mechanisms for SUD Services

Service Type	Eligibility	Authorization	Payment	Data collection
Medicaid-reimbursable service	Medicaid-insured	ASO	ASO	ASO
Medicaid-reimbursable service	Uninsured	ASO	ASO	ASO
Non-Medicaid reimbursable service	Either	Local Authority	Local Authority	ASO

Role of Existing Local Planning Agencies

The MHA and ADAA both have strong, long-standing relationships with local partners. Prior to 1997, Medicaid paid a modest rate to Local Health Departments (LHDs) for mental health outpatient services, which was far below the cost of the actual service. Most other residential and support services, as they emerged, were managed by their respective administrations through central contracts. In general, the local authorities assisted in oversight of private residential and support services providers. They provided service coordination with those providers, as well as with many other local entities such as social services, the mental health/SUD provider community, law enforcement, schools, jails, juvenile justice, Local Management Boards, the judiciary, public defenders and primary care providers. Both administrations also required local plans for needs assessments and capacity development. Eventually, both administrations decentralized much or most of the contractual function to the local authorities.

In the early 1990s, following a Robert Wood Johnson Foundation demonstration grant in Baltimore City, the MHA began to change the nature of the local authorities, developing a network of CSAs responsible for planning and management of the local mental health system. Some CSAs were housed within the LHDs or other governmental structures, while others were established as private non-profit agencies. One county maintains a quasi-governmental CSA. Outpatient services often continued to be provided by the LHDs; administrative and contractual functions, including the contracting of outpatient services with the LHDs, moved to the newly-established CSAs. This transformation progressed further with the implementation of the managed fee-for-service Public Mental Health System (PMHS) in 1997. Within two years, many LHDs found that direct provision of outpatient services in an LHD was often impractical and not cost-effective, and they outsourced many outpatient services to private providers. As a result, less than half of the LHDs currently offer mental health outpatient services, and nearly half of those offer outpatient services on a very limited basis to a limited population. The CSAs are required to develop firewalls between the staff who provide direct services and those who monitor the program.

In addition to oversight of services provided through direct contracts, CSAs also participate in the oversight of the PMHS managed fee-for-service system. This includes referring individuals and families to service providers, meeting with local providers to encourage participation in the PMHS or address community concerns, participating in provider reviews conducted by various agencies, assisting in the coordination of services as appropriate, monitoring residential sites, and monitoring service utilization within their jurisdiction.

SUD service lines and funding expanded considerably during the same time period, and LAAs, which were similar but not identical to CSAs, were developed. While maintaining the original functions for SUD services that had been performed by the LHDs, LAAs have become more

involved in a variety of system-related activities. They are charged with the planning, development and management of a local continuum of care. By assuming contractual functions, local authorities are responsible for following appropriate service procurement procedures, monitoring service quantity and quality, providing technical assistance to providers, monitoring provider outputs and outcomes with respect to contract deliverables, handling and investigating complaints and many other related duties.

CSAs and LAAs have many other responsibilities in common; chief among these is the provision of clinical information and service referrals for individuals and family members. Both entities serve as the focal point of referral for individuals experiencing a crisis in the local community, or for whom existing services are inadequate. Simultaneous referrals to Medicaid and non-Medicaid clinical and support services are common in such situations. Once individuals are linked with appropriate services and supports, the local authority often provides follow-up to ensure the individual has become involved with both clinical and support services as necessary. Such referrals often involve other local agencies, and as a result, both sets of local authorities generally maintain very close ties with the same community providers and partners. CSAs and LAAs also assist in the management of individuals who are super-utilizers of resource-intensive services—inpatient, emergency room and SUD residential services—without engaging in consistent follow-up care.

Both sets of local authorities also provide public information and education, including a role in the training of new law enforcement recruits. Community mental health crisis services are planned and funded by CSAs to be tailored to the unique needs and resources of the local community. Authorities in both areas often have access to safety net emergency funding for individuals in crisis or with particular or unusual needs. This funding can be used to procure services and medications while appropriate entitlement eligibility is determined. Many local authorities also fund participant-operated, recovery-centered services that have become a critical part of the safety net system of care. In addition to providing crisis services for individuals, both entities participate in planning for and responding to emergencies and disasters that occur in the community.

In summary, CSAs and LAAs network at the state and local level to meet individual and family needs, identify and correct system issues and inefficiencies, and ensure that individuals receive the least costly, most appropriate services in the least restrictive setting. They bring in additional resources at the local level, including local government and foundation funding, as well as grants. Further, they collaborate with a broad range of partners to build and maintain relationships critical in facilitating system development and ensuring access to care and support services, and conducting continuous quality management activities. Local authorities are essential partners in operating Maryland’s behavioral health system and in facilitating the coordination of Medicaid and a variety of other services at the local level that cannot be achieved

centrally. They know their local populations well and are generally familiar with those individuals who are in the greatest need of assistance and support, as well as the providers who can offer the most appropriate services.

Currently, the CSAs and LAAs are at various stages of integration at the local level. Some have long been integrated into a single unit, some have merged relatively recently, and others are in the process of merging or planning to merge. These processes must be allowed to proceed at their own pace within each jurisdiction and must be sensitive to local strengths and needs.

How Other Existing Programs Will Operate

The BHA will provide other services currently offered that are generally considered outside the programs and services discussed so far, such as State Psychiatric Facilities and Forensic Services. These services are paid for by MHA and ADAA grants and contracts, local government and foundation funding, grants procured by CSAs and LAAs, State Psychiatric Facility resources and forensic resources. There is likely to be very limited, if any, change in the way these services operate as integration proceeds. To ensure clarity, key services that fall into this category are discussed below and any anticipated changes noted.

State Psychiatric Facilities

The MHA currently operates five State Psychiatric Facilities, including one forensic hospital, and two Residential Institutes for Children and Adolescents (RICAs). Admissions to State hospitals have decreased by 70 percent since 2002. Civil admissions have decreased as a result of a decision that uninsured individuals should attend acute general or private psychiatric units when appropriate rather than a State hospital. The number of forensic admissions has remained approximately the same in FY 2013 as it was in FY 2002.

Forensic Services

The Office of Forensic Services and the forensic departments of the State hospitals are responsible for the evaluation of criminal defendants for competency to stand trial and criminal responsibility. This office also monitors individuals on conditional release from State hospitals. Forensic services provided by the ADAA will be funded through grant funds. Non-treatment services—such as court and other assessments for the criminal justice system and treatment services in a Detention Center or prison—will remain the responsibility of the LAAs. Residential services for court-committed individuals with substance use diagnoses will also remain in place and be paid through local grants.

Community Crisis Services

Community crisis services account for many of the services funded by MHA grants or contracts. In many instances, crisis workers accompany local law enforcement on calls that might involve an individual with a mental health issue. In general, crisis service workers are dispatched when notified of an individual in crisis, regardless of diagnosis or insurance status, which are often unknown. Immediate intervention is usually undertaken as appropriate to defuse the precipitating situation and, if necessary, an appropriate referral is made. It is likely that many such past incidents involved substance use. Going forward, the scope of such services will be expanded to include calls involving, or suspected to involve, an individual with a SUD. Grants and contracts with resources for training local law enforcement offices will be expanded to include education on SUD-related topics.

Participant and Recovery Services

Participant and recovery services also receive significant grant and contract funding. These services include care coordination, continuing care services, recovery coaching, recovery housing and recovery community centers. In the area of mental health, these recovery services have been operating for more than 30 years under the auspices of On Our Own of Maryland (OOOMD) and have moved from a "drop-in" model to a focus on wellness and recovery, including the development of wellness and recovery action plans. Services are open to any member of the public seeking help, regardless of diagnosis or insurance status, and serve as a key part of the safety net system in Maryland. In the SUD area, funding for the recovery services listed above has increased steadily. As with behavioral health integration at the local level, the integration of recovery services is progressing at various rates. For example, regarding Recovery Community Centers, there is complete integration of the programs in some jurisdictions, while others only share space and selected common meeting times; in other jurisdictions, the two entities are either in integration discussions or send representatives to participate in the other's activities. As behavioral health integration proceeds, it is expected that the integration of services and facilities will continue. Data on these services will be submitted to the ASO.

Prevention Services

Though well-developed in SUD, prevention services are not as well-developed in the mental health field. Currently, the ADAA funds a number of prevention activities in all jurisdictions, while the MHA concentrates on suicide prevention and hotline services. Each jurisdiction has a Prevention Coordinator responsible for implementing evidence-based individual and environmental strategies to minimize and mitigate harm from substance use. The field is moving in the direction of greater emphasis on environmental strategies to effect change at a population level. Prevention services generally relate to issues associated with substance use, such as

bullying, tobacco use and community violence. An area of growth is the incorporation of mental health risk and protective factors in local prevention programming.

Maryland is one of three entities involved nationally in working to implement Mental Health First Aid USA (MHFA) in other states, which is now available in all 50 states and has experienced recent growth in Maryland. This program is designed to offer non-mental health professionals a series of strategies for recognizing mental distress or an emerging mental illness; provide simple, immediate and personal level interventions; and connect the person in crisis to an appropriate peer or professional who can offer more intensive and, if appropriate, professional help.

In most cases, the recipients of these types of prevention services are Medicaid participants; therefore, many of these interventions result in a referral to a Medicaid provider. Strong relationships among locally-managed activities and the Medicaid provider community throughout the state are essential to continue the streamlined facilitation of referrals for ongoing care.

How the Current Outcomes Will Need to be Improved and/or Expanded[4]

Improved outcomes are the ultimate measure of whether the new behavioral health model will meet its goals. Currently, both the MHA and ADAA collect and measure outcome-level indicators. The current measures are listed in Attachment 1. Again, data reporting under the new model is expected to be more robust and integrated, allowing the Department to measure additional outcomes. There will also be enhanced data sharing across the system to coordination and outcomes. To improve patient outcomes, the Department recommends expanding its outcome measurement goals to include goals on:

- **Reducing the total cost of care from mental health and addictions services, and also from somatic services, per member per month**. In an integrated system, there will be greater capacity to calculate the total cost of care and evaluate trends and costs over time.

- **Reducing the number of preventable inpatient hospital days through intensive case management for individuals requiring high level, intensive services.** Intensive case management of High Inpatient Utilization (HIU) cases intends to reduce the number of inpatient days required, thereby reducing cost, improving value and providing treatment in the least restrictive environment possible.

[4] This section of the report was prepared in consultation with: the Mental Hygiene Administration (Offices of Adult Services, Child/Adolescent Services, Special Needs Populations, Clinical Services, and Quality Management); the Alcohol and Drug Abuse Administration (ADAA); the University of Maryland, Systems Evaluation Center (SEC); and, the Maryland Psychiatric Research Center (MPRC).

- **Increasing the number of providers in the PBHS cross-trained in both mental health and SUD treatment.** Enhancing the number of dually-trained providers will increase the capacity of the PBHS to provide integrated care.

- **Expanding the Physician Pharmacy Alert System, with special attention to physician alerts for non-adherence to medication**. Preliminary reports to the MHA suggest that providing physicians with alerts about non-adherence to medication is correlated with a reduction in the number of hospital days.

- **Increasing the volume of individuals receiving treatment for a first episode of psychosis in the Early Intervention Program First Episode Clinics.** Early identification and treatment of psychotic disorders can alter the course of illness, reduce disability and maximize the likelihood of recovery. The new behavioral health system will provide increased resources to support first episode programs.

- **Increasing the length of stay across different ASAM levels of care**. A greater length of time spent in treatment programs often leads to improved outcomes for individuals.

- **Reducing overdose deaths in Maryland.** Deaths due to unintentional drug overdose are likely preventable through education, outreach and surveillance. The Governor has set a strategic policy goal to reduce overdose deaths by 20 percent by the end of 2015. A plan to accomplish this is in the early stages of implementation. One vital component is the establishment of a State Opioid Overdose Prevention Plan and localized plans in each jurisdiction.

- **Reducing substance use by Maryland youth aged 12 to 17 through substance use prevention.** The Budget Committees requested that the Department include in its annual Managing for Results (MFR) submission related key goals, objectives, and performance measures. In the area of SUD prevention, the PBHS incorporates a goal and data from the National Survey on Drug Use and Health (NSDUH) on past month substance use by youth.

- **Increasing the number of individuals trained in suicide awareness and prevention.** The Department's efforts to increase the availability of instructors of Mental Health First Aid will ultimately increase the number of newly-trained persons. The Department will also support suicide prevention outreach services provided by the Suicide Prevention Hotline.

Moreover, the Department is in the process of developing additional behavioral health outcome measures in the areas of residential treatment centers and transition-age youth. Behavioral health outcomes are an emerging field. The new system should continuously review new and useful outcome measures and seek to apply these as appropriate.

Consolidating the Current Array of Statutorily Created SUD Programs

The General Assembly queried whether the current array of statutorily-created substance use programs might be more easily-administered as a single block grant. Currently, a separate sub-program code is used for each project, which complicates the administration of both State and local-level funding streams. The Department reviewed these projects and determined that some, but not all, funding streams can be consolidated.

The Department found that funding streams supported by General Funds that do not have special reporting requirements may be consolidated into the existing Substance Abuse Treatment Services Project (M272). Once combined, the funding streams will be tracked individually using the existing Funding by Jurisdiction report, in lieu of separate sub-program codes.

Table 2 provides a list of the sub-program codes the Department recommends consolidating into a single block grant (figures based on FY 2015 Allowance):

Table 2: Sub-Program Codes to be consolidated into a single block grant (General Funds)

Sub-Program	Project Name	FY 15 Amount
M282	Recovery Support Expansion	$11,707,842
M289	SB 512-Children in Need of Assistance-Drug Affected Babies	$1,656,599
M290	Substance Abuse Treatment Outcomes Partnership (STOP)	$6,433,718
M291	HB7-Integration of Child Welfare and Substance Abuse Services	$2,322,364
	Total to be consolidated into M272	$22,120,523
M272	Substance Abuse Treatment Services—Current Funding	$44,876,485
	Substance Abuse Treatment Services—Revised Total	$66,997,008

Federal regulations dictate that certain projects comply with special reporting requirements and spending restrictions. Given restrictions for projects in the Program 2 component, which covers Community Services, such projects (listed in Table 3) should continue as currently-appropriated and maintain separate sub-program codes.

Table 3: Sub-Program Codes to be appropriated and maintained separately

Sub-Program	Project Name	FY 15 Amount
M271	Prevention Services (SAPT Block Grant)	$6,010,910
M273	Substance Abuse Treatment Services (SAPT Block Grant)	$17,832,923
M274	Cigarette Restitution	$21,032,184
M276	Substance Abuse Services for Drug Treatment Court	$1,767,900
M278	Maryland Strategic Prevention Framework (MSPF)	$2,779,564
M279	Whitsitt Expansion and Upper Shore Alternative	$3,079,107
M280	Problem Gambling	$4,146,225
M281	Access to Recovery (ATR)	$3,182,809
M295	Buprenorphine Initiative	$3,380,764
Total Not Consolidated		$63,212,386

The Fiscal Impact of the Model and How Rate-Setting Will Change

Factors that will influence the cost of the new behavioral health integration model are described below.

Adding Medicaid-Covered Substance Use Services under the Responsibility of the ASO

ValueOptions, the current ASO, is only responsible for the administration of specialty mental health services. Under the new model, the ASO will also be responsible for administering substance use services. While it is hard to estimate the cost that vendors responding to the RFP will propose to the Department, examining the current ASO contract provides helpful guidance concerning what to expect. Currently, the Department spends about 1.5 percent of the cost of the service benefit on the ASO. Table 4 highlights these costs.

Table 4. ASO Contract Costs as a Percentage of Service Costs

	$ Millions		
Populations	FY 2011	FY 2012	FY 2013*
Uninsured	$19.8	$18.6	$16.4
Medicaid - State Only Covered services	$44.1	$ 48.1	$48.5
Medicaid-Covered Services with Federal Match	$591.3	$606.5	$602.3
Total	$655.2	$673.2	$667.2
Cost of Administrative Service Organization Contract	$9.97	$10.27	$10.57
% of Service Cost	1.5%	1.5%	1.6%

Note: FY 2013 is not complete since providers have 12 months to bill.

These costs are already accounted for in the Department's expenditures and are not considered new expenditures. Additionally, there will be new Medicaid enrollees in 2014 due to the ACA; however, the impact of those additional enrollees on the ASO expenses would occur regardless of whether the Department implemented its new behavioral health model. As mentioned previously, the most significant changes will be adding full benefits to the PAC program and increasing the income eligibility thresholds for parents and childless adults. Enrollment in the PAC program has increased at an average rate of 19 percent per year from FY 2011 to FY 2013, which will be reflected in the FY 2015 budget amounts.

The Department anticipates that the new performance-based measures and data sharing requirements will increase the costs of the ASO contract. Rather than using the 1.5 percent of Service Cost figure noted above, a conservative estimate would use a slightly higher figure, such as 1.7 percent. Any costs above 1.5 percent would be considered costs due to the new model. In FY 2015, this additional 0.2 percent in administrative costs is estimated to equal $887,000 (Total Funds) or $518,000 (General Funds).[5]

There will also continue to be a need for state-only funding for the uninsured. Despite the provisions of the ACA, there will continue to be an uninsured population, albeit smaller, in addition to services not covered by Medicaid.

Adding substance use services under the responsibility of the ASO will add additional costs to the ASO contract. All outpatient substance use services will be managed by the ASO rather than by the HealthChoice MCOs. The Department is proposing to carve-out certain hospital inpatient services and costs that have a primary diagnosis relating to substance use care, which will be removed from the MCO benefit package. This means medical issues resulting from long-term substance use disorders, such as cirrhosis of the liver, will continue to be the responsibility of the MCOs. (See Attachment 2 for a draft policy on what SUD services would be managed and paid for by the ASO.) The Department has collected expenditure data from the MCOs since the initiation of the substance use expansion on January 1, 2010. Specifically, the MCOs must report how much they spend on outpatient-based substance use treatment (*see* Table 5 for FY 2012 figures).

Table 5. Outpatient Payments by Program and Service Type, FY 2012

	FY 2012		
Program	Non-Pharm	Pharm	Total
FFS	$3,903,248	$811,092	$4,714,340
HealthChoice	$43,912,586	$13,700,388	$57,612,974
PAC	$27,915,033	$9,822,942	$37,737,975
Total	$75,730,867	$24,334,422	$100,065,289

[5] $149,000 of the additional cost is for state-only services that are ineligible for a federal match.

The Department has projected approximately how much will be carved out of the MCO capitation rates, based on the draft policy in Attachment 2 and estimates for adding inpatient services for the PAC population. Our baseline uses actual MCO encounters or claims. MCOs are required to submit claims or encounters to the Department; however, the current data submission process does not include how the MCO paid for the services. The Department, therefore, assumes the MCO paid the claim at the Medicaid fee-for-service rate. This is called "shadow pricing." While inpatient costs do impact the FY 2015 estimate, the largest driver of increased cost can be attributed to growth in enrollment. Again, the PAC program has experienced an average enrollment growth rate of 19 percent over the past three years. These trends are used to project the FY 2015 expenditures. Preliminary estimates are outlined in Table 6.

Table 6. Estimated SUD Medicaid Expenditures – FY 2015 (Preliminary)*

Program	Total Cost
HealthChoice (Includes PAC enrollees with full benefits and projected new enrollees)	$256 million
FFS	$ 13 million
Total	$269 million

**Based on Attachment 2 and Includes Hospital Inpatient Services. Attachment 2 is still under review.*

Removing Substance Use Services from the MCO Benefit Package

The Department will be making a downward adjustment to the rates paid to the MCOs to account for the carve-out of substance use services. The downward adjustment will be for services as well as to modify the administrative costs built into rates. The Department will work with its actuaries to determine the appropriate adjustment. This will occur during the 2015 rate-setting process, which starts in February 2014.

Removing substance use services will also have a negative impact on the revenue that the State receives under the Maryland Health Care Rate Stabilization Fund. The Fund collects monies from a two percent tax on MCO revenue. Removing substance use services from the MCO package and making a negative adjustment to the administrative costs built into rates lowers the amount of revenue against which the two percent is applied. However, the actual tax loss to the Department is only one percent, as the State pays for only part of the tax in the MCO capitation rates. Specifically, the two percent tax is built into the MCO rates, with the State paying one percent and the federal government responsible for one percent. After the State collects the broad-based tax, the revenues are used to cover the general fund expenditures for Medicaid, which receives a 50 percent match. Therefore, the State loses the one percent federal match embedded in capitation rates to cover the MCO cost of the tax. For instance, if the overall MCO capitation rates are lowered by $256 million, the State will no longer need to build $5.12 million into the MCO capitation rates to cover the two percent tax. $2.56 million is covered by the State

and $2.56 million by the federal government. Thus, by removing substance use services from the MCO package, the Department would forgo the $2.56 million federal share.

Managing ADAA Services for the Uninsured

As mentioned above, outpatient services—assessments, counseling, opioid maintenance and intensive outpatient services—will be removed from the local grants provided by the ADAA. The ASO will be responsible for managing and approving these services for both the uninsured and for Medicaid. This will allow the same organization to make service determinations for all populations—both Medicaid and the uninsured.

In FY 2014, the grant services provided to the local jurisdictions included roughly $27.8 million for outpatient services. These are services that would be covered if an individual were enrolled in Medicaid. Assuming, conservatively, that managing these services costs the ASO roughly 1.7 percent of medical services, the annual ASO cost for these services would be $472,600 (see Table 4). These administrative expenses are not eligible for a federal match because they are provided to non-Medicaid enrollees.

Improving Quality of Care and Bending the Cost Curve

Ultimately, the Department expects the new behavioral health model to improve quality of care by promoting better continuity of care, ensuring prior-authorization/service placement criteria are applied consistently across populations, providing more accountability through risk-based performance measures and other initiatives, and aligning incentives across the system. This report previously addressed how the new model will ensure prior-authorization/service placement criteria are applied consistently across populations. A discussion of how the new model will promote better continuity of care by aligning incentives through risked-based performance measures and data-sharing requirements is provided below.

The Department intends to include risk-based performance measures in the ASO contract—possibly as much as ten percent. The risk-based performance measures will be allocated across nationally-recognized outcome measures (*e.g.*, Healthcare Effectiveness Data and Information Set), state-specific outcome measures, customer service metrics and provider service measures.

Additionally, requirements for data sharing will be extensive. Data will be shared with medical homes, MCOs and other programs—such as ACOs—under the direction of the Department. This will facilitate enhanced care coordination and improve the quality of care for individuals.

While these new performance-based measures and data sharing requirements will increase the ASO contract costs, the Department expects that this will be more than offset by a reduction in service costs. For example, if one of the measures selected focused on hospital readmissions, the

Department could expect to bend the cost curve through lower hospital costs. Namely, Medicaid behavioral health inpatient hospital costs are projected to total approximately $162 million in FY 2015. These figures do not include inpatient costs related to somatic care. A one percent reduction in behavioral health inpatient services would save the Department $1.62 million (see Table 7).

Table 7. Summary of New ASO Costs based on FY 2015 projections (Preliminary)

New Costs/ Lost Revenue/ Offsets	Estimated Annual Total Fund Amount (6 Months – Start Date January 1)	Estimated General Fund (6 Months)
1. Adding Medicaid Covered Substance Use Under ASO Contract	$2.3 million	$1.15 million
2. Adding Certain Substance Use Services Provided to Uninsured Under ASO Contract	$236,300	$236,300(ineligible for federal match)
3. New ASO requirements for mental health services (not in baseline)	$738,000- Medicaid $149,000-State-Only Service =$887,000 - Total	$369,000 - Medicaid $149,000 – State-Only Service =$518,000 – Total
4. Lost Revenue from Rate Stabilization Fund	$1.28 million federal	$1.28 million federal
Offsets	Estimated Amount	
1. Adjusting MCO rates	Estimated to equal the ASO contract cost for the HealthChoice Population or $2.3 million.	Estimated to equal the ASO contract cost for the HealthChoice Population or $1.15 million.
Total New Costs/Lost Revenue (after MCO adjustment): $2.03 million (GF)		
Improving Quality of Care and Bending the Cost Curve	One percent reduction in behavioral health inpatient services will save the Department $1.62 million (TF) annually	

The estimates contained in this report assume that future contract costs will be slightly above the existing ratio of administrative costs to medical expenses. If the proposals received for the new contract are substantially lower or higher than the existing contract, the cost estimates in this report should be reconsidered.

Next Steps

The Department plans to release the RFP to procure an ASO for the integrated behavioral health system in early 2014. Further evaluation of the costs of the future ASO contract may be necessary depending on the bids received by the Department in response to the RFP. The Department's goal is to implement the new system in January 2015.

The new model improves outcomes and reduces costs by bending the cost curve. Collaboration with local entities through a streamlined integrated delivery system presents opportunities to

improve care and treatment outcomes for individuals living in Maryland. However, capitalizing on the new model's potential will require significant provider education and training. Moreover, providing performance-based incentives directly to the ASO, MCOs and individual providers will be critical to the program's success, in addition to continued stakeholder engagement. The Department remains committed to this collaborative approach throughout the implementation phase and as the program continues to evolve in the coming years.

ATTACHMENT 1: Outcome Measures Currently Tracked in ADAA and MHA

Outcome Measures Common to Both ADAA and MHA

The MHA and ADAA both collect and analyze data on National Outcome Measures (NOMS), as required by the Substance Abuse and Mental Health Services Administration (SAMHSA). The NOMS embody meaningful, real life outcomes for people who are striving to attain and sustain recovery, build resilience and work, learn, live and participate fully in their communities. Data are collected and analyzed in the following domains:

- Reduced symptomatology from mental illnesses or abstinence from drugs and alcohol;
- Resilience and sustaining recovery, including:
  - Getting and keeping a job, or enrolling and staying in school; and
  - Decreased involvement in the criminal justice system;
- Access to safe and stable housing;
- Improved social connectedness;
- Increased access to services and increased service capacity;
  - Retention in substance use disorder treatment or decreased inpatient hospitalizations for mental health treatment;
  - Improved quality of services provided and improved participant perception of care/services;
- Cost effectiveness; and
- Use of evidence-based treatment and practices.

MHA Outcome Measures

The Outcomes Measurement System (OMS) was developed by the MHA, in collaboration with the Systems Evaluation Center (SEC) and the current ASO, as a tool for tracking how well individuals served in Maryland's PMHS are doing over time. Although designed to track trends in the PMHS as a whole, clinicians are encouraged to use the information in treatment planning. Data is collected regarding psychiatric symptoms, substance use, recovery/resilience, living situation, employment/school, functioning, legal system involvement, smoking and general health. Outpatient mental health treatment providers are required to submit the OMS questionnaire on individuals ages 6 through 64 at admission and every six months during treatment.

The OMS, including items and methods, was developed in collaboration with multiple PMHS stakeholders. Items chosen for inclusion were based on tested reliability and validity of

instruments, feasibility (*e.g.*, time involved, training needed, cost), federal and state reporting requirements, indicators and instruments used by Maryland providers and in other states, and the development of specific questions when there were no appropriate instruments available. The OMS has also been evaluated by stakeholders over time. During its development and just prior to its revision in 2009, focus groups and surveys were conducted with providers regarding OMS content, administration and data submission logistics.

A public online reporting system (OMS Datamart) has been created to present state and county data.[6] Participating providers and CSAs can also access data on individuals whom they serve. Detailed materials to assist both CSAs and providers in using and interpreting data from the OMS Datamart are in development and include dynamic tools that may be used to conduct statistical analyses. Initial reaction to this draft training material for use and interpretation has been quite favorable.

In addition to the OMS, the MHA conducts or collaborates on a number of other processes to collect PMHS outcome information. These include:

- Inpatient cost savings associated with the HIU program, to provide intensive care management for individuals with histories of high inpatient use;
- Increased patient adherence to prescribed medication, associated with the MHA's pharmacy alert system for providers in the mental health system;
- Decreased involvement and exposure to crime and violence and the increase in the number of healthy babies born to women participating in the Chrysalis House Healthy Start Program, a transitional and diagnostic program for pregnant offenders;
- Percentage of approved SSI/SSDI applications for homeless individuals being assisted through the SSI/SSDI Outreach, Access and Recovery (SOAR) program;
- MHA State Facility measures, including seclusion and restraint rates, length of stay, patient/resident injuries, staff injuries and accident leave, as well as outcomes of Health Safety Management Team (HSMT) interventions to reduce injuries;
- Pharmacotherapy quality measures in State facilities, such as decreasing the use of three or more antipsychotics;
- Evidence-Based Practice (EBP) implementation and fidelity monitoring, to include the percentage of approved programs meeting established fidelity threshold, per service type, and
    - Supported employment outcome measures (*e.g.*, percentage of participants employed in a competitive job, among other selected measures);
    - Assertive Community Treatment (ACT) outcome measures (selected measures in multiple domains of interest); and
    - Family psychoeducation (subject to OMS data reporting);

[6] *See* http://maryland.valueoptions.com/services/OMS_Welcome.html.

- Maryland Mental Health Employment Network (MMHEN) Ticket-to-Work, to include the number of participants whose tickets have been assigned to MMHEN; the number of participants who have received benefits counseling through MMHEN; and wages earned by MMHEN participants;
- Claims, OMS and service authorization data mining and research;
- An annual Consumer Perception of Care survey, which contains a number of outcome-related survey items; and
- A biennial provider survey.

ADAA Performance and Outcome Measures

The ADAA assesses the following performance measures/targets for services performed through its grants programs:

- Adults and adolescents in State-supported treatment programs should have treatment episodes of at least 90 days;
- Adults and adolescents who complete and/or are transferred or referred from State-supported intensive outpatient programs should enter another level of treatment within thirty days of disenrollment;
- Individuals who complete and/or are transferred or referred from State-supported residential detoxification programs should enter another level of treatment within 30 days of disenrollment;
- The number of individuals using substances in the 30 days before completion of/or transfer/referral from non-detoxification treatment will be reduced among adolescents and adults from the number of individuals who were using substances in the 30 days before admission to treatment;
- The number of employed adults at completion of/or transfer/referral from non-detoxification treatment will increase from the number of adults who were employed at admission to treatment;
- The number of individuals arrested during the 30 days before discharge from non-detoxification treatment will decrease for adolescents and adults from the number arrested during the 30 days before admission;
- Continuum of Care: Individuals disenrolled from a Level III.7 will enter another level of care within 30 days;
- Individuals disenrolled from a Level III.5 will enter another level of care within 30 days;
- Individuals disenrolled from a Level III.3 will enter another level of care within 30 days;
- Percentage of individuals dropping out of treatment against clinical advice will be reduced;

- Percentage of female participants with dependent children completing and referred from Level III.7 short-term residential and continuing in another level of care within 30 days will be increased;
- Percentage of participants completing Level I outpatient and entering Continuing Care within 30 days will be increased; and
- Reduce overdose deaths by 20 percent by the end of calendar-year 2015.

ATTACHMENT 2: Medicaid SUD services authorized and paid for by the ASO [Preliminary]

Community-Based, Inpatient Hospital and Outpatient Services

Community-Based Regardless of Diagnosis	
Procedure Codes	**Description**
H0001	Alcohol/drug assessment
H0004	Behavioral health counseling and therapy
H0005	Alcohol/drug group counseling
H0014	Alcohol and/or drug services; ambulatory detoxification
H0015	Alcohol and/or drug services; intensive outpatient
H0020	Alcohol and/or drug services; methadone administration and/or service

Inpatient Hospital With Primary Diagnosis	
Revenue Codes	**Description**
0116	Detoxification, Private Bed
0126	Detoxification, Semi-Private Bed
0136	Detoxification, 3-4 Beds
0156	Detoxification/Ward
0912	Partial Hospitalization – Less Intensive
0913	Partial Hospitalization – Intensive
0944	Drug rehabilitation
0945	Alcohol rehabilitation

Outpatient Hospital With Primary Diagnosis	
Revenue Codes	**Description**
0906	Intensive Outpatient Services – Chemical Dependency
0912	Partial Hospitalization – Less Intensive
0913	Partial Hospitalization – Intensive
0944	Drug rehabilitation
0945	Alcohol rehabilitation

Emergency Room with Primary Diagnosis (See diagnosis listed below)	
Revenue Codes	**Description**
0450	General classification
0451	EMTALA
0452	ER Beyond EMTALA
0456	Urgent Care

0459	Other Emergency Room

Intermediate Care Facility – Addiction Services	
Provider Type	**Description**
55	Services provided to children in ICF-A will be carved out and paid for by the ASO

Pharmacy	
Proprietary Name	**Other Names**
Antabuse	Disulfiram
Buprenorphine	Subutex
Buprenorphine/ Naloxone	Suboxone (exclude IM, IV, transdermal formulations of buprenorphine), Zubsolv
Naltrexone	Vivitrol, ReVIa
Naloxone	Narcan
Acamprosate	Campral
Nicotrol Spray	
Nicotine Patch	
Chantix	Varenicline

Laboratory	
Procedure Codes	**Description**
80100	Drug screening, multiple classes, chromatography, each procedure.
80101	Drug screening, multiple classes, single drug class method, each drug class.
80102	Drug confirmation, each procedure.
80103	Tissue preparation for drug analysis.
80104	Drug screening, multiple classes, other than chromatographic method, each procedure.
82055	Alcohol (ethanol): any specimen except breath
82145	Amphetamine or methamphetamine
G0431	Drug screening,qualitative; multiple classes by high complexity test method, per patient encounter
G0434	Drug screen, other than chromatographic; any number of drug classesby CLIA waived test or moderate complexity test, per patient

Diagnosis Codes

Inpatient & Outpatient Hospital
Hospitals must bill one of the following ICD-9 codes (as the primary diagnosis) with one of the inpatient or outpatient revenue codes listed on page 1.

Diagnosis Codes	Description
291.0	Alcohol withdrawal delirium
291.3*	Alcohol induced psychotic disorder with hallucinations
291.4	Idiosyncratic alcohol intoxication
291.5	Alcohol induced psychotic disorder with delusions
291.8	Other specified alcohol induced mental disorder
291.81	Alcohol withdrawal
291.82	Alcohol induced sleep disorders
291.89	Other
291.9	Unspecified alcohol induced mental disorder
292.0	Drug withdrawal
292.1	Drug induced psychotic disorders
292.11	Drug induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations
292.2	Pathological drug intoxication
292.8	Other specified drug induced mental disorders
292.81	Drug induced delirium
292.84**	Drug induced mood disorder
292.85	Drug induced sleep disorders
292.89	Other
292.9	Unspecified drug induced mental disorder
303.0	Acute Alcoholic Intoxication Unspecified drunkenness
303.9	Other and unspecified alcohol dependence
304.0***	Opioid Type dependence
304.1	Sedative, hypnotic or anxiolytic dependence
304.2	Cocaine dependence
304.3	Cannabis dependence
304.4	Amphetamine and other psychostimulant dependence
304.5	Hallucinogen dependence
304.6	Other specified drug dependence
304.7	Combination of opioid type drug with any other
304.8	Combination of drug dependence excluding Opioid type drug
304.9	Unspecified drug dependence
305.0****	Alcohol Abuse
305.1	Tobacco use disorder
305.2	Cannabis abuse
305.3	Hallucinogen abuse
305.4	Sedative, hypnotic or anxiolytic abuse
305.5	Opioid abuse
305.6	Cocaine abuse
305.7	Amphetamine or related acting sympathomimetric abuse

Inpatient & Outpatient Hospital	
Hospitals must bill one of the following ICD-9 codes (as the primary diagnosis) with one of the inpatient or outpatient revenue codes listed on page 1.	
Diagnosis Codes	**Description**
305.8	Antidepressant type abuse
305.9	Other, mixed or unspecified drug abuse
648.3	Drug dependence
790.3	Excessive blood level of alcohol

** 291.1 and 291.2 are not part of the carve-out*

*** 292.82 and 292.83 are not part of the carve-out*

**** All 304.xx codes will be included in the carve-out*

***** All 305.xx codes will be included in the carve-out*

Crosswalk: ICD-9 to ICD-10 Codes

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
291.0	Alcohol withdrawal delirium	F10.231	Alcohol dependence with withdrawal delirium
291.3	Alcohol induced psychotic disorder with hallucinations	F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
291.4	Idiosyncratic alcohol intoxication	F10.929	Alcohol use, unspecified with intoxication, unspecified
291.5	Alcohol induced psychotic disorder with delusions	F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
291.8	Other specified alcohol induced mental disorder	F10.14	Alcohol abuse with alcohol-induced mood disorder
		F10.15	Alcohol abuse with alcohol-induced psychotic disorder
		F10.18	Alcohol abuse with alcohol induced disorder
291.81	Alcohol withdrawal	F10.239	Alcohol dependence with withdrawal, unspecified
291.82	Alcohol induced sleep disorders	F10.182	Alcohol abuse with alcohol-induced sleep disorder
		F10.282	Alcohol dependence with alcohol-induced sleep disorder
		F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder
291.89	Other	F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
		F10.180	Alcohol abuse with alcohol-induced anxiety disorder
		F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
		F10.188	Alcohol abuse with other alcohol-induced disorder
		F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
		F10.280	Alcohol dependence with alcohol-induced anxiety disorder
		F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
		F10.288	Alcohol dependence with other alcohol-induced disorder
		F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
		F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
291.9	Unspecified alcohol induced mental disorder	F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
292.0	Drug withdrawal	F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
292.1	Drug induced psychotic disorders	F15.15	Other stimulant abuse with stimulant-induced psychotic disorder
		F15.95	Other stimulant use, unspecified with stimulant-induced psychotic disorder
292.11	Drug induced psychotic disorder with delusions	F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
292.2	Pathological drug intoxication	F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
292.8	Other specified drug induced mental disorders	F15.14	Other stimulant abuse with stimulant-induced mood disorder

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
		F15.15	Other stimulant abuse with stimulant-induced psychotic disorder
		F15.18	Other stimulant abuse with other stimulant-induced disorder
292.84	Drug induced mood disorder	F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
292.85	Drug induced sleep disorders	F11.182	Opioid abuse with opioid-induced sleep disorder
		F11.282	Opioid dependence with opioid-induced sleep disorder
		F11.982	Opioid use, unspecified with opioid-induced sleep disorder
		F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
		F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
		F13.982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
		F14.182	Cocaine abuse with cocaine-induced sleep disorder
		F14.282	Cocaine dependence with cocaine-induced sleep disorder
		F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder
		F15.182	Other stimulant abuse with stimulant-induced sleep disorder
		F15.282	Other stimulant dependence with stimulant-induced sleep disorder
		F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder
		F19.182	Other psychoactive substance abuse with psychoactive substance-induced

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
			sleep disorder
		F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
		F19.982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder
292.89	Other	F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
		F11.181	Opioid abuse with opioid-induced sexual dysfunction
		F11.188	Opioid abuse with other opioid-induced disorder
		F11.222	Opioid dependence with intoxication with perceptual disturbance
		F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
		F11.281	Opioid dependence with opioid-induced sexual dysfunction
		F11.288	Opioid dependence with other opioid-induced disorder
		F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
		F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
		F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
		F11.988	Opioid use, unspecified with other opioid-induced disorder
		F12.122	Cannabis abuse with intoxication with perceptual disturbance
		F12.159	Cannabis abuse with psychotic disorder, unspecified
		F12.180	Cannabis abuse with cannabis-induced anxiety disorder
		F12.188	Cannabis abuse with other cannabis-induced disorder
		F12.222	Cannabis dependence with intoxication with perceptual disturbance
		F12.259	Cannabis dependence with psychotic disorder, unspecified
		F12.280	Cannabis dependence with cannabis-induced anxiety disorder

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
		F12.288	Cannabis dependence with other cannabis-induced disorder
		F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
		F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
		F12.980	Cannabis use, unspecified with anxiety disorder
		F12.988	Cannabis use, unspecified with other cannabis-induced disorder
		F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
		F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
		F13.181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
		F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
		F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
		F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
		F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
		F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic oranxiolytic-induced disorder
		F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic oranxiolytic-induced psychotic disorder, unspecified
		F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic oranxiolytic-induced anxiety disorder
		F13.981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
			oranxiolytic-induced sexual dysfunction
		F13.988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic oranxiolytic-induced disorder
		F14.122	Cocaine abuse with intoxication with perceptual disturbance
		F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
		F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
		F14.188	Cocaine abuse with other cocaine-induced disorder
		F14.222	Cocaine dependence with intoxication with perceptual disturbance
		F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
		F14.280	Cocaine dependence with cocaine-induced anxiety disorder
		F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
		F14.288	Cocaine dependence with other cocaine-induced disorder
		F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
		F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
		F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
		F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
		F14.988	Cocaine use, unspecified with other cocaine-induced disorder
		F15.122	Other stimulant abuse with intoxication with perceptual disturbance
		F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
		F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
		F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
		F15.188	Other stimulant abuse with other stimulant-induced disorder
		F15.222	Other stimulant dependence with intoxication with perceptual disturbance
		F15.259	Other stimulant dependence with stimulant-induced psychotic disorder,unspecified
		F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
		F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
		F15.288	Other stimulant dependence with other stimulant-induced disorder
		F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance
		F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
		F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
		F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
		F15.988	Other stimulant use, unspecified with other stimulant-induced disorder
		F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
		F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
		F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
		F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder
		F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
		F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder,unspecified
		F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
		F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
		F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
		F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder,unspecified
		F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
		F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder
		F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
		F17.208	Nicotine dependence, unspecified, with other nicotine-induced disorders
		F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
		F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
		F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
		F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
		F18.180	Inhalant abuse with inhalant-induced anxiety disorder
		F18.188	Inhalant abuse with other inhalant-induced disorder
		F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
		F18.280	Inhalant dependence with inhalant-induced anxiety disorder
		F18.288	Inhalant dependence with other inhalant-induced disorder
		F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
		F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
		F18.988	Inhalant use, unspecified with other inhalant-induced disorder
		F19.122	Other psychoactive substance abuse with intoxication with perceptualdisturbances

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
		F19.159	Other psychoactive substance abuse with psychoactive substance-inducedpsychotic disorder, unspecified
		F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxietydisorder
		F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexualdysfunction
		F19.188	Other psychoactive substance abuse with other psychoactive substance-induceddisorder
		F19.222	Other psychoactive substance dependence with intoxication with perceptualdisturbance
		F19.259	Other psychoactive substance dependence with psychoactive substance-inducedpsychotic disorder, unspecified
		F19.280	Other psychoactive substance dependence with psychoactive substance-inducedanxiety disorder
		F19.281	Other psychoactive substance dependence with psychoactive substance-inducedsexual dysfunction
		F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
		F19.922	Other psychoactive substance use, unspecified with intoxication with perceptualdisturbance
		F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
		F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
		F19.981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
		F19.988	Other psychoactive substance use, unspecified with other psychoactivesubstance-induced disorder

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
292.9	Unspecified drug induced mental disorder	F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
303.0	Acute Alcoholic Intoxication Unspecified drunkenness	F10.120	Alcohol abuse with intoxication uncomplicated
		F10.129	Alcohol abuse with intoxication specified
		F10.220	Alcohol dependence with intoxication uncomplicated
		F10.229	Alcohol dependence with intoxication specified
303.9	Other and unspecified alcohol dependence	F10.9	Alcohol use, unspecified
304.0	Opioid Type dependence	F11.20	Opioid Dependence Uncomplicated
		F11.220	Opioid Dependence W/Intoxication Uncomplicated
		F11.221	Opioid Dependence W/Intoxication Delirium
		F11.222	Opioid Dependence W/Intoxication W/Perceptual DIST
		F11.229	Opioid Dependence W/Intoxication Unspecified
		F11.23	Opioid Dependence W/Intoxication W/ Withdrawal
		F11.24	Opioid Dependence W/Opioid-Induced Mood Disorder
		F11.250	Opioid Dependence W/Induced Psychotic D/0 W/Delusions
		F11.251	Opioid Dependence W/Induced Psychotic D/0 W/Hallucinogens
		F11.259	Opioid Dependence W/Opioid-Induced Psychotic D/0 Unspecified
		F11.281	Opioid Dependence W/Opioid-Induced Sexual Dysfunction
		F11.282	Opioid Dependence W/Opioid-Induced Sleep Disorder
		F11.288	Opioid Dependence W/Other Opioid-Induced Disorder
		F11.29	Opioid Dependence W/IJNS Opioid Induced Disorder
304.1	Sedative, hypnotic or anxiolytic dependence	F13.2	Sedative , hypnotic or anxiolytic-related dependence
304.2	Cocaine dependence	F14.2	Cocaine dependence
304.3	Cannabis dependence	F12.2	Cannabis dependence
304.4	Amphetamine and other	F19.2	Other psychoactive substance

ICD-9 Codes	ICD 9 Description	ICD-10 Equivalent	ICD 10 Description
	psychostimulant dependence		dependence
304.5	Hallucinogen dependence	F16.2	Hallucinogen dependence
304.6	Other specified drug dependence	F19.2	Other psychoactive substance dependence
304.7	Combination of opioid type drug with any other	F19.20	Othpsychoactive substance depend uncomplicated
304.8	Combination of drug dependence excluding Opioid type drug	F19.2	Other psychoactive substance dependence
304.9	Unspecified drug dependence	F19.9	Other psychoactive substance use, unspecified
305.0	Alcohol Abuse	F10.1	Alcohol Abuse
305.1	Tobacco use disorder	F17.2	Nicotine dependence
305.2	Cannabis abuse	F12.1	Cannabis abuse
305.3	Hallucinogen abuse	F16.1	Hallucinogen abuse
305.4	Sedative, hypnotic or anxiolytic abuse	F13.1	Sedative, hypnotic or anxiolytic abuse
305.5	Opioid abuse	F11.1	Opioid abuse
305.6	Cocaine abuse	F14.1	Cocaine abuse
305.7	Amphetamine or related acting sympathomimetric abuse	F19.1	Other psychoactive substance abuse
305.8	Antidepressant type abuse	F19.1	Other psychoactive substance abuse
305.9	Other, mixed or unspecified drug abuse	F19.1	Other psychoactive substance abuse
648.3	Drug dependence	F10.2	Alcohol dependence
		F11.2	Opiod dependence
		F12.2	Cannabis dependence
		F13.2	Sedative, hypnotic or anxiolytic-related dependence
		F14.2	Cocaine dependence
		F15.2	Other stimulant dependence
		F16.2	Hallucinogen dependence
		F18.2	Inhalant dependence
		F19.2	Other psychoactive substance dependence
790.3	Excessive blood level of alcohol	R78.0	Finding of alcohol in blood