

**Kristin Milne-Glasser, LCADC, SAP**

As a non-funded private provider of addictions services, including court-ordered services, I am offering the following comments and concerns, based on my attendance at consultants' meetings and the reading of their report issued 12-05-11:

1. Court-ordered and pre-trial clients cannot use commercial insurance plans to pay for treatment. A DUI or drug arrest is not considered to be a "medical necessity" in commercial insurance contracts and authorization criteria, nor is seeking authorization "for the convenience of the provider or the patient" considered to be medical necessity. This is why many providers have no commercial contracts. For those of us who do contract with commercial insurance, we can only bill insurance if a client has an existing psychiatric diagnosis and is medication compliant.
2. The cash-based fee-for-service providers, especially those of us who also do not bill Medicaid and are not Medicaid providers, comprise a significant percentage of treatment providers in the state. We do not want to be included in the regulations that require data collection for outcomes research. We are already exempt from having to report data now and want to retain that opt out position as is also provided to clients as their individual right to refuse to participate in any research without prejudice.
3. For private providers who accept no other source of funding but who do bill Medicaid, we do not want to report client treatment data for any clients other than those whose treatment is billed to Medicaid.
4. Non-funded private providers object strenuously to the imposition of a national accreditation survey fee of a minimum of \$7 to \$8K per site. Scalability very likely disqualifies most smaller programs from being eligible for having to do CARF accreditation. If receiving state funds to pay for CARF accreditation then qualifies an otherwise private program to be considered to be a funded program, a significant number of private programs would opt out of that offer and subsequently be closed. Smaller private programs have long histories and close working relationships with ancillary mental health and medical providers, as well as with court agencies and DSS, in their communities. To close these programs by imposing CARF fees that we cannot afford to pay would be an injustice to both clients who need easy access to care, but also to those agencies and ancillary providers in our communities who rely on our programs and staff to quickly admit clients to treatment due to not having extensive waiting lists like public programs and much larger programs.
5. Non-funded private providers who are not Medicaid providers could continue to be surveyed by OHCQ every 3 years or OHCQ could easily design a re-attestation process, similar to the 3-month re-attestation process used by CAQH credentialing, allowing non-funded private providers to re-attest all required documents of personnel, fire inspections, etc. every year between site surveys and extend the site survey period to every 5 years.
6. As a longstanding private non-funded provider, I would be willing to accept 10% of the health department medically indigent clients unable to be admitted to treatment at the health department within 30 days in lieu of having to pay for CARF accreditation

fees. Health departments currently hold clients in "orientation status" groups prior to being evaluated and/or admitted to treatment when these clients are supposed to be referred out to local providers but aren't being referred.

7. The workforce issue will not be easily resolved. Licensed social workers and professional counselors and psychologists with 5 years or more of documented work experience in addictions treatment could be grandfathered in as supervisors and as addictions counselors. However, those new to the field need to complete the IC&RC exam and certification classes in addictions in order to be competent in the field. As an employer of trainees and licensed therapists for many years, I have never retained one trainee, intern or licensed therapist who started working in the addictions field. The licensed therapists either didn't like the nature of the work and extensive paperwork and documentation required by certified programs, or they found the additional college credit classes for certification to be too expensive and time-consuming to complete for certification as addictions counselors.

It is dangerous to assume that a license in social work and professional counseling and psychology qualifies as competency in delivering addictions treatment. My experience with these individuals informs me that certification through IC&RC is critical to developing competency to work with addictions issues. They know virtually nothing about addictions after completing graduate programs, and after extensive training in our facility, they leave the field.

Smaller programs are doing all that we can in training and supervising many new trainees and counselors, and we employ support staff who live in our communities. Smaller programs are stakeholders in the integration of behavioral health who, unlike much larger health systems and funded programs, operate at no cost whatsoever to the state but provide key services and relationships to the communities we serve. Maryland cannot afford to risk losing these programs for all of the reasons cited above.

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