

# **Behavioral Health Analysis**

**Presented to:**

**The Maryland Department of Health and Mental Hygiene  
Alcohol and Drug Abuse Administration  
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**2010**

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## **BEHAVIORAL HEALTH ANALYSIS**

State governments have been hit particularly hard by the economic downturn over the past few years. Over the last three years, state governments have had to address budget shortfalls of over 420 billion dollars. To partially address the budget shortages several states implemented consolidation initiatives between substance abuse and mental health services. These efforts include clinical and programmatic integration of mental health and substance abuse services, enhancements for more efficient use of financial and human resources by merging similar administrative functions and maximizing Medicaid reimbursement.

By redesigning their respective mental health and substance abuse systems, states established a single point of entry into the service system for recipients of care. These efforts also fostered coordination, collaboration, and communication among service providers for the efficient utilization of funding streams, resources and personnel as well as the expansion of the provider base and the movement of the system to evidenced-based practices. Provider accountability, creativity, and efficiency were among the goals, as were the expansion of data systems and the implementation of technology-based services to expand access in rural areas.

These efforts have received additional impetus by the passage of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act. These new laws are expected to mandate coverage for more mental health and substance abuse prevention and treatment services and expand the populations covered for these services through both private and public insurance sources. With these new opportunities however, new challenges will come. Behavioral health providers will have to be prepared to navigate systems to demonstrate the medical necessity of their services, effectively bill for services, and demonstrate positive outcomes of their services.

This study will provide an analysis of the organization, financing, regulation, and management in several similar states, highlighting both those strategies which have proven successful and those which have not. The information contained herein is envisioned to assist the Alcohol Drug Abuse Administration (ADAA) in the development of an evolutionary action plan on how behavioral health systems in Maryland can be reorganized, managed and reimbursed.

### **BACKGROUND**

State alcohol and substance abuse agencies are critical components of State government that emerged nationally in the 1970s under distinct administrative, financing and regulatory structures to plan and ensure the provision of services primarily to low income individuals. The State substance abuse agencies play a pivotal role in planning and providing effective substance abuse prevention and treatment programs and in working collaboratively with other State agencies and key stakeholders to ensure quality public substance abuse services contribute positively to the

State's overall health and welfare. When substance abuse services were in their infancy in the early 1970s, funding for drug abuse in Maryland, and most other states, came primarily from the federal government while alcoholism services were largely state-funded services under the purview of the Mental Hygiene Administration (MHA). In the late 1970s, alcohol treatment services were moved from the MHA to the Alcohol and Drug Abuse Administration (ADAA). Over time State funds, many targeted to specific population groups, were invested in ADAA services. ADAA also gained responsibility for the regulation of privately-funded services. Currently, the ADAA is the single state agency responsible for developing, regulating, and operating programs for substance abuse training, research, prevention and treatment. These tasks are accomplished in conjunction with federal and local governments and private service providers. The ADAA is responsible for planning, regulating and providing fiscal management and technical assistance in the areas of:

- Community Services
- Management Services
- Information Services
- Quality Assurance Services

Funding for services is provided through grants and contracts to private and non-profit providers and local health departments. In some cases, grants or contracts are made with local subdivisions that in turn either provide services and/or contract with service providers. The ADAA's continuum of services includes prevention programs and community-based addictions treatment programs including community based outpatient, primary, and emergency care, and residential services including intermediate care facilities, halfway houses, and long term programs. For FY 2011, the ADAA budget allowance of \$148.1 million includes \$87.5 million in general funds (57%), \$33.9 million in Federal Substance Abuse Prevention and Treatment Block Grant Funds (22%), \$20.8 million in Special Funds (17%), and \$5.7 million in Reimbursable Funds (3%). Maryland spends approximately \$25.88 per capita on addiction services, \$5.90 of which comes from the federal block grant.

In recent years, Maryland and other states have experienced a decline in revenue. The decline in public revenue coupled with the need to develop an enhanced, coordinated system of services for individuals with co-occurring disorders and the desire to achieve greater clinical and financial efficiency in the provision of services, has led many States to initiate organizational and programmatic reform efforts. These efforts include but are not limited to the adoption of evidence-based practices, engagement of managed care organizations and integration of operational functions previously carried out separately by the mental health and addiction administrations. These efforts have received additional impetus by the passage of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act. These new laws are expected to mandate coverage for more mental health and substance abuse prevention and treatment services and expand the populations covered for these services through both private and public insurance sources. With these new opportunities however, will come new challenges. Providers will have to be prepared to navigate systems to demonstrate the medical necessity of their services, effectively bill for services, and demonstrate positive outcomes of their services.

This report is envisioned to contribute to the ADAA’s decision making process regarding system preparation, development, implementation, and coordination by informing the ADAA on a broad variety of issues. The report will examine the organization and structures of state and local governments in the management, regulation, and reimbursement of behavioral health services, investigating those areas which have proven most successful in assisting consumers with their recovery from behavioral disabilities. Specifically, the following questions will be examined in several states and their successes and challenges explored with a particular emphasis on determining the applicability of lessons learned to Maryland:

- How is behavioral healthcare funded, reimbursed and managed in other states comparable to Maryland?
- Is the behavioral health system carved in or out of the Medicaid Program?
- What behavioral health services are covered in states with a “carve out”?
- What substance abuse services are covered under Medicaid in states that were surveyed?
- What substance abuse prevention, treatment and recovery services are covered by Federal/State grant funds in states that were surveyed?
- Are the mental health and substance abuse systems combined or separate at the state level including functions such as fiscal, data, compliance, and clinical?
- If combined, are state funds integrated at the point of distribution? If so, what substance abuse services are covered?
- What funding distribution method(s) is used by each state surveyed?
- What is the management structure for behavioral health services at the local and state level including such issues as 1) how services are purchased (fee-for-service, cost reimbursement, etc; 2) what mechanism(s) is used to reimburse services (e.g., contract, capitated managed care, ASO); and 3) management and oversight roles and responsibilities of state and local authorities in terms of fiscal, data collection and validation, quality of care, and compliance with Federal and State regulations?
- How are reimbursement rates for direct care services determined?
- What are the strengths, weaknesses and lessons learned about the surveyed states’ behavioral health system including areas such as carve in/carve out; integration of mental health and substance abuse; and lack or absence of integration of mental health and substance abuse?
- What are the advantages and disadvantages of the following: 1) Maryland’s current behavioral health system structure at the state level; 2) integration of substance abuse and mental health state administrations (ADAA, MHA) in Maryland; and 3) carve out of substance abuse services in Maryland?

## **STUDY PURPOSE**

The ADAA engaged Health Management Consultants, LLC (HMC) to gather information from a select number of states that are comparable to Maryland and that have transformed or initiated transformation of their behavioral health systems. The study will provide an analysis of the organization, financing, regulation, and management in other states, highlighting both those strategies which have proven successful and those which have not. This information is

envisioned to assist the ADAA in the development of an evolutionary action plan on how behavioral health services in Maryland could be reorganized, managed and reimbursed.

## **STUDY APPROACH**

The project consultants used a multi-faceted approach to gather information. This included a review of available documents, telephone interviews with representatives from selected states, telephone discussions with individuals from select national organizations and the development and administration of a questionnaire. The questionnaire, guided largely by the questions posed in the Request for Proposals dated March 24, 2010 entitled, *Maryland Alcohol Drug Abuse Administration's Behavioral Health Analysis*, was also designed to take in a number of features that collectively indicate the degree of focus, state of readiness, capacity, and factors that lead states to reorganize their substance abuse and/or mental health agencies and the processes used to implement the changes. The questionnaire consisted of an overlapping set of impressions drawn from the questions raised by the ADAA and from informal conversations with representatives from the following organizations:

- National Association of State Alcohol and Drug Abuse Directors (NASADAD), Washington, D.C.
- National Association of State Mental Health Directors (NASMHPD), Alexandria, VA
- Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville MD
- National Association of Mental Health Planning and Advisory Councils (NAMHPAC), Alexandria, VA
- Association of Persons Affected by Addiction (APAA), Dallas, Texas
- National Association of County Behavioral Health and Developmental Disability Directors (NACBHDDD), Washington D.C.,
- The NASMHPD National Research Institute (NRI), Alexandria, VA

Identifying states that are similar (demographically and geographically) to Maryland proved to be challenging. For example, Wisconsin has a total population count numerically close to Maryland (approximately 5.6 million people according to 2009 United States Census), but unlike Maryland, Wisconsin has sixty-seven counties, compared to Maryland's governmental jurisdictions that consist of twenty-three counties and Baltimore City. Likewise, Maryland and Wisconsin both have an alcohol and drug abuse system in which the state is responsible for allocating state and federal funding for the provision of substance abuse services, but in Wisconsin the counties are statutorily responsible for administering services (Wisconsin Chapter 51). In Maryland the counties are required to have a local drug and alcohol abuse council that develops local plans, strategies and county specific priorities for meeting the needs of individuals in need of services (Maryland Health General Article Section 8-1001, Chapters 237 and 238).

In addition, the consultants reviewed the organizational structure, programmatic and fiscal design of the all the remaining forty –eight (48) states' mental health and addiction administrations. Information was gleaned from the 2009 State Mental Health Authority Organizational Chart prepared by the National Association of State Mental Health Program

Directors Research Institute (NRI). (See Exhibit C). This information included the location of the addiction and developmental disabilities agencies with reference to the state mental health administration, organizational relationship among these agencies, and information regarding the use of an independent managed care organization to provide and/or administer mental health and/or addiction services. After examining this table, it was clear that no state was entirely comparable to Maryland. In consultation with the ADAA, the following states were selected based on commonalities and/or recent initiatives from which the lessons learned may be beneficial to Maryland as it considers next steps:

1. Arizona
2. Colorado
3. Nebraska
4. New Mexico
5. New York
6. West Virginia
7. Wisconsin
8. Wyoming

Unfortunately, several issues arose during the attempt to survey the selected states. In all but two states, the respondent was someone other than the Commissioner. Because the time period of this study occurred during the preparation of future years' budgets as well as common summer vacation time, for those empowered to approve the release of the information their responses were often delayed. The emergence of health care reform in the political debate for the 2010 election also hampered the attempt to get information due to a variety of reasons (one state had imposed a moratorium on the release of information). Furthermore, not all respondents answered all questions. Attempts were made to integrate information from as many sources as possible to supplement the information that was obtained from the state survey process.

## **STATE PROFILES**

### **Arizona**

Arizona's mental health and addictions services are integrated into a single agency located in the health department. The Division of Behavioral Health Services (DBHS) plans, administers, and monitors a system of comprehensive, regionalized services that include prevention, intervention, and treatment for individuals and families. In Arizona, both mental health and substance abuse services are carved out of the Medicaid managed care program to the Arizona Department of Health Services, parent organization for the DBHS.

Behavioral health services are managed by four regional behavioral health authorities which serve six geographic service areas and three tribal areas. These entities contract with providers for a broad range of services. The behavioral health authorities reimburse providers on a fee-for-service basis. Treatment services include behavioral health counseling and therapy, assessment, evaluation and screening and other professional services. Rehabilitation services provided include skill development and training, psychiatric rehabilitation, cognitive rehabilitation, health

promotion, and psycho-education and ongoing support. In addition to medication services, medical services include laboratory and methadone management. Case management, personal care, peer support, and home care training are among the support services provided with interpreting and sign language services included. A range of crisis intervention services (mobile, office based and telephone), inpatient treatment (hospital, sub-acute, and residential treatment centers), and short and long term residential services are also provided.

## **Colorado**

In 2006, Colorado's addiction and mental health systems were merged to increase efficiency by integrating services while also being asked by advocates and consumers to better address co-occurring issues. Two previously distinct agencies have integrated their administrative and programmatic functions into the following four areas:

- Community programs
- Data and evaluation
- Business and support services
- Public policy and planning

Both substance abuse and mental health services are carved out of the Medicaid program and are managed by a behavioral managed care organization.

The majority of federal substance abuse block grant funding is focused on prevention services. State funds are used to fund intensive outpatient services, intensive residential services, and detoxification services. Medicaid reimbursement is limited to outpatient, detoxification, and intensive outpatient for non-targeted population groups including families below 150% of poverty level, elderly below 250% of poverty, and single adults who have SSI and are disabled. Reimbursement rates are calculated by the state. Services are integrated at the provider level.

## **Nebraska**

Mental health and substance abuse services in Nebraska underwent a significant change with the passage of a Nebraska Behavioral Health Services Act in 2004. As a result of that Act, a behavioral health disorder was defined as inclusive of mental illness or addictive behaviors such as alcoholism, drug abuse, or problem gambling. The Division of Behavioral Health is now one of six divisions in a Department of Health and Human Services and serves as the State Authority for both Mental Health and Alcohol and Substance Abuse Services.

This division administers and manages non-Medicaid public behavioral health services through both direct service contracts and Regional Behavioral Health Authorities. Medicaid services for mental health are carved out of the managed care program. Nebraska currently uses the services of a behavioral health managed care organization not only to reimburse behavioral health providers on fee-for-service basis but also to facilitate the delivery and management of behavioral health services. This organization also assists the state in upgrading data management

systems. Nebraska services offered include a range of preventive services and inpatient, outpatient, and residential treatment services.

### **New Mexico**

New Mexico's mental health and addiction services are under a single umbrella organization located in a department of human services. Funding for behavioral health services from fifteen agencies in New Mexico are centralized into a single purchasing collaborative which contracts with an independent behavioral health managed care organization. The behavioral managed care organization is charged with purchasing a full range of mental health and substance abuse prevention and treatment services. In addition, 41 Core Service Agencies, operating throughout the state, provide wrap-around services for the consumers with the highest needs.

The Behavioral Health Collaborative is tasked with tracking all expenditures for behavioral health services; creating a single delivery system that emphasizes prevention, recovery, and resiliency and that ensures access to these services statewide; attending to regional and cultural differences in monitoring service delivery; procuring and overseeing the services of a single services purchasing entity, including monitoring service capacity and utilization as well as measuring performance and outcomes; comprehensive planning including meeting State and federal requirements, and data management and decision support including service definitions, rate setting, and system performance and outcomes. The Collaborative is also charged with licensing and certification of providers and providing oversight for fraud and abuse.

### **New York**

Addiction services in New York are administered by the Office of Alcoholism and Substance Abuse Services (OASAS) which is located in the Department of Mental Hygiene and has cabinet level status. The OASAS directly operates thirteen centers providing short term inpatient rehabilitation and treatment services; it also oversees and/or funds prevention providers (300) and treatment providers (1,200). The OASAS provides planning, training, and quality monitoring for the provider system. The services which are provided include crisis, inpatient rehabilitation, residential, outpatient and methadone treatment. It also gathers information needed for planning and national reporting. Funding is distributed largely through contracts some of which are overseen by partners in county government. Because there is no Medical Assistance funding, there are no issues regarding carve in/carve out. Although current planning does not encompass formal integration of services and administrative functions or the use of independent managed care organizations, the OASAS does work closely with the Office of Mental Health and other agencies to provide coordinated services.

### **West Virginia**

In 2006, West Virginia undertook an extensive planning effort to redesign its mental health and substance abuse care systems to establish a single point of entry, a brokerage model for behavioral health services. Through this effort coordination, collaboration, and communication among partners were to be facilitated. Goals included the efficient utilization of funding streams,

resources and personnel; expansion of the provider base; improvement of consumer access; and movement of the system to evidenced-based practices. Provider accountability, creativity, and efficiency were among the objectives, as were the expansion of data systems, and the implementation of technology-based services to expand access in rural areas.

The administration of addiction and mental health services is located in the Bureau for Behavioral Health and Facilities which is part of the Department of Health and Human Resources. During 2010, the Bureau was reorganized from three disability based Sections into the Division of Adult Behavioral Health, the Division of Children's Behavioral Health, and the Division of Intellectual and Developmental Disabilities and Long Term Care. This reorganization has had the practical effect of joining substance abuse and mental health services into age specific divisions.

Effective January 2011, West Virginia will adopt an integrated funding model for substance abuse, mental health, developmental disabilities, child welfare and temporary assistance for needy families recipients into a capitated managed care system under the auspices of three managed care organizations.

### **Wisconsin**

In Wisconsin addiction services are part of the state mental health authority which is located in the health department. In the area of substance abuse, Wisconsin funds outpatient, crisis and residential services including intermediate care facilities, halfway houses, and long term placements.

The state provides federal block grant and state funding to counties or consortia of counties. Counties also contribute significant funding. Counties contract with providers who offer addiction, mental health or both services. These sources account for about 77% of all funding for services. Additionally, about 10% of funding comes from Medicaid managed care programs and 13% comes from the Medicaid fee-for-service system. In general, funding for substance abuse relies more heavily on federal, state and county sources and less on Medicaid and private insurance.

### **Wyoming**

Wyoming's mental health and addiction services are administered by a single agency located in a health department. Wyoming integrated its mental health and addiction services in 2001. In Wyoming federal block grant funds are used to provide community outpatient and residential treatment services, community prevention services, and selected residential services. State general funds are used to fund outpatient services. Funding is provided to counties; some provide services directly while others contract with private non-profit providers or Community Mental Health Centers for service provision. Reimbursement rates are negotiated with each provider. Wyoming's Medicaid system does not have managed care at this time.

The integration of the mental health and substance abuse systems was accomplished precipitously. Many providers were actually able to adjust to the change relatively rapidly because they were already providing both mental health and addiction services and were therefore able to consolidate several contracts into one or two new contracts. The integration of state staff however, was a difficult process that resulted in the loss of many experienced staff who felt that the integration resulted in too great an expansion of their areas of responsibility. It was suggested that a more measured implementation of integration would have been more beneficial for the state staff.

## **LESSONS LEARNED**

State governments have been hit particularly hard by the economic downturn. Over the last three years, state governments have had to address budget shortfalls of over \$420 billion dollars. This erosion of state budgets and the increased recognition of the co-morbidity between mental health and substance abuse led the selected states to:

- Integrate similar administrative functions performed by the mental health and addiction administrations.
- Integrate clinical services previously delivered independently by mental health and addiction providers.
- Explore opportunities and mechanisms to combine funding streams.
- Develop multi-year plans with stakeholder involvement for integration efforts.

The administrative areas that were integrated at the state-level included training, fiscal management, data collection, provider credentialing, and oversight of provider's compliance with regulations. Clinical services that have been integrated encompassed an array of services ranging from prevention to inpatient treatment with access to care based on medical necessity rather than a clinical diagnostic classification.

The managed care system design also varied greatly from state to state. Five of the selected states carved out mental health and addiction services from primary care services. These states used an independent managed care organization solely dedicated to the provision of behavioral health services to assist in the managing the care of service recipients. The use of a managed care entity was viewed as a means to ensure the provision of cost effective evidence-based medically necessary services.

In some instances the managed care entity contracted directly with the state behavioral health agency; in other instances the managed care entity contracted directly with a regional or county-based service agency approved by the state. Medicaid and state general funds were allocated to the managed care entity to reimburse providers on a fee-for-service basis for services rendered. The types of services and the reimbursement rates were established by the state behavioral health agency in conjunction with the state Medicaid Office and the managed care entity. The state behavioral health agency and the Medicaid Office have shared oversight of the managed care entity with the Medicaid Office retaining the fiscal fiduciary responsibilities as the single state

agency for Medicaid. The specific services offered varied greatly from state to state but generally ranged from prevention and outpatient to residential and inpatient treatment.

While no state was exactly like Maryland in its demographic and geographic make up, the states referenced herein did have the “lived” experience of two or more years of organizational reform activity. Despite the differences in the demographic and geographic profiles of each state as compared to Maryland, there are several overlapping and recurring principles embedded in each state’s approach. Overall, respondents identified several common themes as stated below:

- Stakeholders including providers, service recipients, state and county officials and advocates must be included in all planning and implementation phases.
- The change process in order to be successful must emphasize and embrace a system of care that is consumer-focused, recovery-oriented, and evidenced-based.
- The incorporation of financing strategies that can support services for co-occurring disorders integrated at the level of the provider agency is essential to any change process.
- The use of Medicaid funds to maximize alcohol and substance abuse service provision must be included in the overall reform framework.
- The engagement of an independent managed care organization should be considered to ensure the provision of effective, evidenced-based, medically necessary services. .
- The reform efforts should be implemented in a deliberate and thoughtful manner that does not disrupt the provision of services to recipients and maintains the fiscal integrity of providers.
- The reform efforts need to ensure that all stakeholders are aware of the vision and expected outcomes, planned timetable for implementation and expected outcomes.

## **QUESTIONS AND ANSWERS**

Each query that was posed in the solicitation is presented with a corresponding summary of the responses received from the States:

### **How is behavioral healthcare funded, reimbursed and managed in other states comparable to Maryland?**

Five of the states referenced herein contract with an experienced independent behavioral health managed care organization. The provision of services is based on medical necessity. The types of services and the reimbursement rates are established by the state behavioral health agency in conjunction with the state Medicaid Office and the managed care entity. The state behavioral health agency and the Medicaid Office have shared oversight of the managed care entity with the Medicaid Office retaining the fiscal fiduciary responsibilities as the single state agency for Medicaid. The specific services offered varied greatly from state to state but generally ranged from prevention and outpatient to residential and inpatient treatment. County governments are

involved in annual service planning, recruitment of service providers, and monitoring the activities of the managed care organization.

**Is the behavioral health system carved in or out of the Medicaid Program?**

In five of the selected states the service delivery system design is carved out under the auspices of the state behavioral health agency.

**What behavioral health services are covered in states with a carve out?**

The services vary from state to state. Please see the listing by state provided as Exhibit A.

**What substance abuse services are covered under Medicaid in states that were surveyed?**

The services vary from state to state. Please see the listing by state provided as Exhibit A.

**What substance abuse prevention, treatment and recovery services are covered by Federal/State grant funds in states that were surveyed?**

- Outreach and education
- Outpatient
- Screening and assessment
- Detoxification
- Crisis Intervention

**Are the mental health and substance abuse systems combined or separate at the state level including functions such as fiscal, data, compliance, and clinical?**

In seven of the selected states included in this report the mental health and substance abuse systems' administrative functional areas such as fiscal, data, compliance, clinical and training are combined.

It should be noted that the integration of functional areas can prove to be difficult. For example, in Wyoming integration resulted in the loss of many experienced staff who felt that the integration resulted in too great an expansion of their areas of responsibility. Colorado, on the other hand, has taken a more measured approach on the agency's readiness and staff attrition. As certain positions become vacant, the tasks associated with the position are combined with tasks associated to mental health and addiction matters.

**If combined, are state funds integrated at the point of distribution? If so, what substance abuse services are covered?**

State funds are integrated at the point of distribution. The services typically covered may include but are not limited to:

- Behavioral health counseling and therapy

Screening and assessment  
Health promotion  
Laboratory  
Methadone management  
Intensive outpatient  
Intensive residential  
Detoxification services

**What funding distribution method(s) is used by each state surveyed?**

The majority of states referenced within this report distribute funds through an independent behavioral health managed care organization using a fee for service reimbursement system.

**What is the management structure for behavioral health services at the local and state level including such issues as 1) how services are purchased (fee-for-service, cost reimbursement, etc; 2) what mechanism(s) is used to reimburse services (e.g., contract, capitated managed care, ASO); and 3) management and oversight roles and responsibilities of state and local authorities in terms of fiscal, data collection and validation, quality of care, and compliance with Federal and State regulations?**

For the majority of selected states, at the state level mental health and substance abuse services are integrated into a single agency. The role of local jurisdiction varies. In some states, local jurisdictions are responsible for planning, implementing, monitoring and overseeing expenditures in conjunction with a managed behavioral health care organization. Services are reimbursed on a fee for service basis.

The behavioral health divisions retain statutory responsibility for fiscal, data collection, validation, quality of care and compliance with Federal regulations but share these responsibilities; some may delegate these responsibilities in whole or in part to the managed care organization. Specific roles and responsibilities are detailed in contracts and agreements between the state and the behavioral health care organizations.

**How are reimbursement rates for direct services determined?**

Typically, reimbursement rates are established by a state rate setting committee under the auspices of the behavioral health division.

**What are the strengths, weaknesses and lessons learned about the surveyed states' behavioral health system including areas such as carve in/carve out; integration of mental health and substance abuse; and lack or absence of integration of mental health and substance abuse? What are the advantages and disadvantages of the following: 1) Maryland's current behavioral health system structure at the state level; 2) integration of substance abuse and mental health state administrations (ADAA, MHA) in Maryland; and 3) carve out of substance abuse services in Maryland?**

The states referenced in this report found that integrating administrative functions between the mental health and substance abuse divisions to be beneficial in reducing redundancy and strengthening collaboration between the two systems. Under the new Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 signed by President Obama in March 2010, it is envisioned that substance and mental health services will become integrated with primary care. The role of the mental health and addiction carve outs has not been definitively answered. What is known is that under the Patient and Affordable Care Act, the Medicaid program will play an even greater role in the financing and delivery of mental health and substance use services. According to Pam Hyde, J.D., newly appointed Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that oversees behavioral health, providers who are not familiar with third party billing may be at a disadvantage. SAMHSA intends to request the Centers for Medicare and Medicaid to provide reimbursement for an array of services many of which may be currently funded by the Substance Abuse and Prevention Block Grant (SAPT). The SAPT is proposed to be repurposed to support services not funded by Medicaid. (National Mental Health Grantee and Data Meeting, Washington, D.C., June 2010).

Maryland's carve out system has inadvertently positioned mental health providers to adapt to the Medicaid driven reimbursement system. More recently, substance abuse treatment providers were provided a greater opportunity to participate in a third party billing process such as fee-for-service. Both fields have gained critical experience prior to the full enactment of the Patient and Affordable Care Act.

## **SUMMARY**

In considering potential changes to Maryland's behavioral health system, some discussion of recent developments within SAMHSA can be instructive. A reorganization of the agency has been announced directed at strengthening collaboration between mental health and substance abuse and streamlining administrative functions across the agencies. Four offices will handle administrative functions across the programmatic Centers. These include the Office of Communications, Office of Financial Resources, Office of Policy, Planning, and Innovation, and Office of Management, Technology and Operations. SAMHSA hopes to realize both administrative savings by unifying these functions across the agencies and to foster collaboration and communication among its Centers. Additionally, the role of the previous Office of Applied Science, which previously worked in the area of substance abuse, has been expanded into the Center for Behavioral Health Statistics and Quality that will integrate mental health data and information into its purview. States may want to follow SAMHSA's lead, as well as those of some of states referenced herein, and begin to organize and foster collaboration amongst the mental health and addiction agencies and service delivery systems; reframe systems from continuing to foster fragmentation that reinforces separate planning, data collection, and funding systems. (National Mental Health Grantee and Data Meeting, Washington, D.C., June 2010) Maryland's thirteen years of experience in providing mental health services under the auspices of an administrative service organization can certainly provide the ADAA with a wealth of information on how to convert a predominately grant based system of care to a fee-for-service system that incorporates managed care principles and techniques while employing the county-

based partners in the overall behavioral health delivery system. Maryland's carve out system for mental health has helped to balance cost as well increase quality, utilization, and access to services.

## REFERENCES

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Maryland Health-General Article, sec. 8-1001, Chapters 237 and 238, 2004.

Pam Hyde, Speech , National Mental Health Grantee and Data Meeting, Washington, D.C., June 2010.

State Mental Health Organizational Structure Survey, 2009. National Research Institute.

### Telephone Interviews:

Ted Johnson, Chair West Virginia Mental Health Planning Council,  
South Charleston, West Virginia;

Theodore Lutterman, Director Research Analysis, National Research Institute;  
Rob Morrison, Executive Director, National Association of State Alcohol and Drug  
Abuse Directors, Washington, D.C.

Korin Schmidt, Administrator Wyoming Mental Health and Substance Abuse Services  
Wyoming Department of Health, Cheyenne, Wyoming

Charles Smith, Deputy Director, Division of Behavioral Health,  
Colorado Department of Human Services, Denver, Colorado;

Mike Maples, Assistant Commissioner, Division of Mental Health and Substance Abuse  
Texas Department of State Health Services, Austin, Texas;

United States Census Bureau, 2009.

Wisconsin Chapter 51, State Substance Alcohol, Drug Abuse, Developmental Disabilities and  
Mental Health Act (2008).

### Exhibit A: Summary of Selected States

	SA & MH Integrated-State Level	SA & MH Providers Integrated	Mental Health Services Covered by Medicaid	MH Carved Out	Substance Abuse Services Covered by Medicaid	SA Carved Out
<b>AZ</b>	Yes	Yes	<ul style="list-style-type: none"> <li>-Inpatient Hospital Services</li> <li>-Non-Hospital Inpatient Psychiatric Facility Services</li> <li>-BH Therapeutic Home Care Services</li> <li>-Community Service Agency</li> <li>-Rural SA Transition Agency Services</li> <li>- BH Residential Services (L 2&amp;3)</li> <li>-Outpatient Clinic Services</li> <li>-Screening</li> <li>-Evaluation/Assessment</li> <li>-Individual, Group, Family Therapy &amp; Counseling</li> <li>-Psychotropic Medication Adjustment &amp; Monitoring</li> <li>-Partial Care (Supervised BH Day Program)</li> <li>-Partial Care (Therapeutic Day Program)</li> <li>-Partial Care (Medical Day Program)</li> <li>-Emergency BH Care</li> <li>-Behavior Management (BH Personal Care Services)</li> <li>-Behavior Management (Family Support/Home-Care Training)</li> <li>-Behavior Management (BH Self-help Peer Support)</li> <li>-Psychosocial Rehabilitation (Living Skills Training)</li> <li>-Psychosocial Rehabilitation (Supported Employment Services)</li> <li>-Psychosocial Rehabilitation (Health Promotion)</li> <li>-BH Case Management</li> </ul>	Yes	-Covered services are presented as Behavioral Health services and listed under Mental Health in 4 <sup>th</sup> column	Yes

			<ul style="list-style-type: none"> <li>-Nursing Services</li> <li>-Psychotropic Medication</li> <li>-Laboratory &amp; Radiology Services for Diagnosis &amp; Medication Regulation</li> <li>-Transportation</li> <li>-Opioid Agonist Treatment</li> <li>-Respite Care</li> </ul>			
<b>CO</b>	Yes	Yes	<ul style="list-style-type: none"> <li>-Community MH Services Program (Special Program)</li> <li>-Licensed Psychologist Services</li> <li>-Inpatient Psychiatric Services (Children &lt;21 years &amp; Adults &gt; 64 years)</li> </ul>	Yes	-Outpatient SA Treatment	Yes
<b>NE</b>	Yes	Yes	<ul style="list-style-type: none"> <li>-Psychiatric Services for Individuals &gt; 20 years: (Outpatient, Day Treatment, Adult Inpatient Hospital Psychiatric Services, Inpatient Hospital Services for Clients &gt;64 years)</li> <li>-Services for Children &amp; Adolescents: (Outpatient, Middle Intensity Services, Treatment Foster Care Services, Treatment Group Home Services, Residential Treatment Services, Hospital Services, Inpatient MH Services, Inpatient MH Services in IMDs)</li> </ul>	Yes	-Services for Children & Adolescents: (Outpatient, Middle Intensity Services, Treatment Foster Care Services, Treatment Group Home Services, Residential Treatment Services, Hospital Services)	No
<b>NM</b>	Yes	Yes	<ul style="list-style-type: none"> <li>-Psychosocial Rehabilitation Intervention</li> <li>-Medication Monitoring</li> <li>-Individual Therapeutic Intervention</li> <li>-Group Therapeutic Intervention</li> <li>-Pharmacotherapy</li> <li>-Assessment &amp; Master Treatment Plan</li> <li>-Periodic Plan Review</li> <li>-Psychological Evaluation</li> <li>-Crisis Intervention</li> <li>-Behavior Management</li> <li>-Crisis Stabilization</li> <li>-Day Treatment</li> <li>-Psychotherapy</li> <li>-Psychotherapy Group</li> </ul>	Yes	-Covered services are presented as Behavioral Health services and listed under Mental Health in 4 <sup>th</sup> column	Yes

			<ul style="list-style-type: none"> <li>-Family Therapy</li> <li>-Play Therapy</li> <li>-Pre-Decision Counseling</li> <li>-Psychological Report</li> <li>-Consultation</li> <li>-Case Management</li> <li>-Early Intervention Therapy</li> </ul>			
<b>NY</b>	No	No	<ul style="list-style-type: none"> <li>-Evaluation</li> <li>-Outpatient</li> <li>-Inpatient</li> <li>-Intensive Psychiatric Rehabilitation Treatment</li> <li>-Continuing Day Treatment for Adults</li> <li>-Day Treatment for Children</li> <li>-SED Clinic Services for Children</li> <li>-Intensive Case Management</li> <li>-Supportive Case Management</li> <li>-Home &amp; Community Based Services for SED Children</li> <li>-Partial Hospitalization</li> <li>-Assertive Community Treatment</li> <li>-Personalized Recovery Oriented Services,</li> <li>-Rehabilitation Services</li> <li>-Family Based Treatment</li> </ul>	No	<ul style="list-style-type: none"> <li>-Evaluation</li> <li>-Outpatient</li> <li>-Inpatient</li> <li>-Inpatient Detoxification</li> <li>-Outpatient Detoxification</li> </ul>	No
<b>WV</b>	Yes	No	<ul style="list-style-type: none"> <li>-Behavioral Health Clinic Services (Psychological Testing, Psychiatric Diagnostic Interview Examination, Screening, Developmental Testing, Service Planning, Pharmacologic Management, Injection [Risperidone], MH Assessment, Physician Coordinated Care Oversight Services, Case Coordination, Individual &amp; Group Counseling, Supportive Counseling, Comprehensive Medication Services, Day Treatment, Crisis Intervention, Community Psychiatric Supportive Treatment, Therapeutic Behavioral Services, Non-Emergency Transportation</li> </ul>	Yes	<ul style="list-style-type: none"> <li>-Covered services are presented as Behavioral Health services and listed under Mental Health in 4<sup>th</sup> column</li> <li>-Subutex &amp; Suboxone</li> </ul>	Yes

			-Behavioral Health Rehabilitation Services (services listed above + Assertive Community Treatment, Comprehensive Community Support Services, & Residential Children's Services)			
<b>WI</b>	Yes	Yes	-Community Support Program (range of treatment, rehabilitation & support services) -Comprehensive Community Services (individualized community-based psycho-social rehabilitation services) -Community Recovery Services (Community Living Supportive Services, Supportive Employment & Peer Support) -Crisis Intervention -Case Management -Outpatient Services	Yes	-Comprehensive Community Services (individualized community-based psycho-social rehabilitation services)	Yes
<b>WY</b>	Yes	Yes	-Children's Mental Health Waiver (Family Care Coordination, Individualized Child Training & Support, Family Training & Support) -Clinical Assessment -Comprehensive Medication Service -Individual Rehabilitative Service -Intensive Individual Rehabilitative Service -Certified Peer Specialists -Psychosocial Rehabilitation Services -Children's Psychosocial Rehabilitation Services -Individual/Family Therapy -Group Therapy -Intensive Child Treatment Services -Adult Case Management -Ongoing Case Management -Psychiatric Evaluation/Determination of Appropriate Placement	No	-Alcohol/Drug Assessment -Individual/Family Therapy -Comprehensive Medication Therapy -Psychosocial Rehab Services -Group Counseling -Individual Rehab Services -Intensive Individual Rehab -Certified Peer Specialists -Case Management -Case Management (Youth)	

**EXHIBIT B:  
BEHAVIORAL HEALTH ANALYSIS  
QUESTIONNAIRE**

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Section I: Organizational Design**

1. Is the state substance abuse and mental health agency separated or integrated?
  - a. Separate \_\_\_\_\_
  - b. Integrated \_\_\_\_\_
  - c. Notes:
  
2. If separated, are the substance abuse and mental health agency located in the same umbrella agency and the agency heads report to the same supervisor?
  - a. Same Umbrella
    - i. Yes \_\_\_\_\_
    - ii. No \_\_\_\_\_
  - b. Supervisor
    - i. Yes \_\_\_\_\_
    - ii. No \_\_\_\_\_
  - c. Notes:
  
3. If integrated, for how long and what were the precipitating factors that lead to the integration?
  - a. Time Integrated \_\_\_\_\_
  - b. Precipitating Factors
  - c. Notes:
  
4. If integrated what functions are combined and what functions remain separate?

<ol style="list-style-type: none"><li>a. Combined<ol style="list-style-type: none"><li>i.</li><li>ii.</li><li>iii.</li><li>iv. Fiscal</li></ol></li></ol>	<ol style="list-style-type: none"><li>b. Remain Separate<ol style="list-style-type: none"><li>i.</li><li>ii.</li><li>iii.</li><li>iv. Fiscal</li></ol></li></ol>
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- |                |                |
|----------------|----------------|
| v. Data        | v. Data        |
| vi. Compliance | vi. Compliance |
| vii. Clinical  | vii. Clinical  |
| b. Notes:      |                |

5. Are the substance abuse and/or mental health services carved in or out of the Medicaid program?

- a. Carved In \_\_\_\_
- b. Carved Out \_\_\_\_
- c. Notes:

6. Is substance abuse or mental health integrated with primary care?

- a. Yes \_\_\_\_
- b. No \_\_\_\_
- c. Notes:

## Section II. Local Authority

1. What role does county government play in the overseeing/administering substance abuse and mental health services?

- a.
- b.
- c. Notes:

2. Does the county government have any responsibility for:

- a. Funding of direct services
  - i. Yes \_\_\_\_
  - ii. No \_\_\_\_
  - iii. Notes:
- b. Fiscal management of local, state and/or federal funds
  - i. Local
    1. Yes \_\_\_\_
    2. No \_\_\_\_
    3. Notes:
  - ii. State
    1. Yes \_\_\_\_
    2. No \_\_\_\_
    3. Notes:
  - iii. Federal

1. Yes
  2. No
  3. Notes:
- c. Data collection
- i. Yes \_\_\_
  - ii. No \_\_\_
  - iii. Notes:
- d. Quality of care
- i. Yes \_\_\_
  - ii. No \_\_\_
  - iii. Notes:
- e. Assuring provider compliance with Federal and State regulations
- i. Yes \_\_\_
  - ii. No \_\_\_
  - iii. Notes:

### **Section III: Service Array and Funding**

1. What substance abuse prevention, treatment and recovery services are funded by:
  - a. Federal block grant funds?
    - i.
    - ii.
    - iii.
    - iv. Notes:
  - b. State general funds?
    - i.
    - ii.
    - iii.
    - iv. Notes:
  - c. Medicaid?
    - i. Yes \_\_\_
    - ii. No \_\_\_
    - iii. Notes:
2. Are any of the above funds administered by an administrative service organization (ASO), a behavioral health organization (BHO) or managed care organization (MCO)?
  - d. ASO
    - i. Yes \_\_\_
    - ii. No \_\_\_

- iii. Notes:
  - e. BHO
    - i. Yes \_\_\_
    - ii. No \_\_\_
    - iii. Notes:
  - f. MCO
    - i. Yes \_\_\_
    - ii. No \_\_\_
    - iii. Notes:
2. Regardless of the purchaser, who and how are reimbursement rates calculated for direct care services?
- a. Notes:

#### **Section IV: Service System Effectiveness**

1. In your opinion is the current organizational design of the substance abuse system (taking into consideration today's economic conditions) within your State adequate?
  - a.
  - b.
  - c.
  - d. Notes:
2. What are the strengths of the system?
  - a.
  - b.
  - c.
  - d. Notes:
3. What are the weaknesses?
  - a.
  - b.
  - c.
  - d. Notes:
4. If you had the chance to redesign the system what would you do differently?
  - a.
  - b.
  - c.

- d. Notes:
5. What lessons have been learned during the integration process?
- a.
  - b.
  - c.
  - d.
  - e. Notes:

## EXHIBIT C:

### 2009 State Mental Health Authority Profile, National Research Institute

State	Organization and Structure			Relationship to AOD and MR/DD Agency		Use of Managed Care
	SMHA Located in State Department	Levels between Commissioner & Governor	SMHA Director Reports to Board	Alcohol & Drug Abuse	Intellectual Disabilities (MR/DD)	
Alabama	Independent	0	Yes	Part of SMHA	Part of SMHA	No Managed Care
Alaska	Human Services	2	No	Part of SMHA	Same Umbrella	No Managed Care
Arizona	Health Dept	1	No	Part of SMHA	Other Agency	MH & SA
Arkansas	Human Services	2	No	Part of SMHA	Same Umbrella	No Managed Care
California	Human Services	1	No	Other Agency	Other Agency	MH only
Colorado	Human Services	2	No	Part of SMHA	Same Umbrella	MH only
Connecticut	Independent	0	Yes	Part of SMHA	Other Agency	MH & SA
Delaware	Human Services	1	No	Part of SMHA	Same Umbrella	MH & SA
DC	Independent	1	No	Other Agency	Other Agency	MH only
Florida	Human Services	2	No	Same Umbrella	Other Agency	MH & SA
Georgia	Human Services	1	Yes	Part of SMHA	Part of SMHA	MH & SA
Hawaii	Health Dept	2	No	Same Umbrella	Same Umbrella	MH & SA
Idaho	Human Services	2	No	Part of SMHA	Same Umbrella	No Managed Care
Illinois	Human Services	3	No	Same Umbrella	Same Umbrella	No Response
Indiana	Human Services	1	No	Part of SMHA	Same Umbrella	MH & SA
Iowa	Human Services	1	Yes	Other Agency	Part of SMHA	MH & SA
Kansas	Human Services	2	No	Same Umbrella	Same Umbrella	MH & SA
Kentucky	Human Services	3	No	Part of SMHA	Part of SMHA	No Managed Care
Louisiana	Health Dept	1	No	Same Umbrella	Same Umbrella	MH only
Maine	Human Services	1	No	Other Agency	Part of SMHA	MH & SA
Maryland	Health Dept	1	Yes	Same Umbrella	Same Umbrella	MH & SA
Massachusetts	Human Services	1	Yes	Same Umbrella	Same Umbrella	MH & SA
Michigan	Health Dept	1	No	Part of SMHA	Part of SMHA	MH & SA
Minnesota	Human Services	2	No	Same Umbrella	Same Umbrella	MH & SA
Mississippi	Independent	1	Yes	Part of SMHA	Part of SMHA	No Managed Care
Missouri	Independent	0	Yes	Same Umbrella	Same Umbrella	No Managed Care
Montana	Human Services	1	Yes	Other Agency	Same Umbrella	No Managed Care
Nebraska	Human Services	1	No	Part of SMHA	Same Umbrella	MH only
Nevada	Human Services	0	Yes	Part of SMHA	Part of SMHA	MH & SA
New Hampshire	Human Services	2	No	Same Umbrella	Same Umbrella	MH only
New Jersey	Human Services	3	No	Same Umbrella	Same Umbrella	MH only
New Mexico	Human Services	1	Yes	Same Umbrella	Same Umbrella	MH & SA
New York	Independent	1	No	Other Agency	Other Agency	No Response
North Carolina	Human Services	1	No	Part of SMHA	Part of SMHA	MH & SA
North Dakota	Human Services	1	No	Part of SMHA	Same Umbrella	No Managed Care
Ohio	Independent	0	Yes	Other Agency	Other Agency	No Managed Care
Oklahoma	Independent	1	Yes	Part of SMHA	Other Agency	No Managed Care
Oregon	Human Services	1	No	Part of SMHA	Same Umbrella	MH & SA
Pennsylvania	Human Services	1	No	Other Agency	Same Umbrella	MH & SA
Rhode Island	Independent	1	No	Part of SMHA	Part of SMHA	No Managed Care
South Carolina	Independent	1	Yes	Other Agency	Other Agency	MH & SA
South Dakota	Human Services	1	No	Same Umbrella	Same Umbrella	No Managed Care
Tennessee	Independent	0	No	Part of SMHA	Other Agency	MH & SA
Texas	Health Dept	2	No	Part of SMHA	Same Umbrella	MH & SA
Utah	Human Services	1	No	Part of SMHA	Same Umbrella	MH only
Vermont	Human Services	1	Yes	Same Umbrella	Same Umbrella	MH & SA
Virginia	Independent	1	Yes	Part of SMHA	Part of SMHA	MH & SA
Washington	Human Services	2	No	Same Umbrella	Same Umbrella	MH only
West Virginia	Human Services	1	No	Part of SMHA	Part of SMHA	MH & SA
Wisconsin	Health Dept	1	Yes	Part of SMHA	Same Umbrella	MH & SA
Wyoming	Health Dept	1	No	Part of SMHA	Same Umbrella	No Managed Care