Maryland-DC Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

SB 581 Behavioral Health Care Coordination Value-Based Purchasing Pilot Program

SUPPORT House Health & Government Operations Committee March 28, 2023

MDDCSAM is a chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

MDDCSAM supports Senate Bill 581. For the past several decades, the cost of healthcare has outpaced the improvement of outcomes in all of medicine, including behavioral health. This is at least in part to the traditional fee for service model of reimbursement. In this model, a plethora of services may be utilized and reimbursed without consideration of outcomes. The inherent incentive is for providers to utilized more reimbursable services, rather than deliver services based on the individual needs of the patient. Furthermore, there is a disincentive to provide additional or alternative services that may be beneficial for the patient, but are not reimbursed.

For example, family therapy is typically not a reimbursable service during residential or outpatient substance use disorder treatment. Family therapy is an integral part of treating substance use disorders that likely improves outcomes, but many programs offer very little family therapy because the cost to do so may be prohibitive. In addition, there is no financial incentive to follow patient outcomes after patients have completed programs, so we still have much to learn about how to best treat patients. Finally, the costs of treating patients is increasing faster than the rise in reimbursement, making it increasingly difficult to create and continue quality programs.

Value based reimbursement (VBR) is an alternative reimbursement model that potentially could correct the above issues with the fee for service model. In a VBR model, reimbursement is contingent on positive outcomes. This incentivizes providers to track patient outcomes over time, which, as noted, have been lacking in behavioral health, and in particular, substance disorder treatment. In addition, it allows providers to utilize a wide spectrum of therapeutic interventions based on individual needs rather than being limited to a number of reimbursable services that often do not take into consideration the complex needs of patients or the social determinants of health (housing, employment, wellness, etc…). Providers will be rewarded for innovation, which will ultimately be needed to truly improve outcomes. Payors and providers will both assume financial risk in a VBR model and the providers that administer quality of care will be rewarded, while those that do not will find it difficult to continue without changing.

If executed well, VBR would reduce the cost of care while improving patient outcomes. There is ample evidence to support this in other areas of medicine. However, there is no single model that has proven to be successful in behavioral health. In order to design an effective model, pilot programs should be implemented and evaluated. To place this burden on individual providers/programs and insurance companies would likely cause unnecessary delays and a variety of models that could be difficult to navigate.

We ask for a favorable report.

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