



September 20, 2012

The Honorable Charles J. Milligan, Jr.  
Deputy Secretary for Health Care Financing  
Maryland Department of Health and Mental Hygiene  
201 W. Preston Street, 5<sup>th</sup> Floor  
Baltimore, MD 21201

Dear Deputy Secretary Milligan:

Thank you for the opportunity to comment on the Option 2 recommendation of the Steering Committee. Amerigroup wants to thank the members of the Steering Committee and all the participants in the Work Groups. A tremendous amount of work, thought and time has been committed by all involved and the results can be seen in the material produced by the Steering Committee and by the various work groups.

Amerigroup is disappointed in the recommendation put forth by the Steering Committee. Our opinion on Option 2 was clearly stated in our previously submitted letter of August 7, 2012. To quote briefly:

Finally, Amerigroup strongly opposes Option 2, the Risk-bearing Carve-Out, because it would only serve to exacerbate existing problems in the program today. Under this option, MCOs would only be responsible for somatic care and be further disadvantaged in serving members with substance abuse and/or mental health care needs. If those needs were to go unmet, it would result in a significant negative impact on the MCOs ability to effectively deliver other health care services. Our experience has shown that members who have unmet substance abuse and/or mental health needs are less likely to access treatment for other illnesses and conditions.

We believe that Option 1, the fully integrated at-risk proposal, is the only one of the three options that truly represents healthcare integration. While we understand the significant concerns regarding this option, we maintain that the Department has the ability to identify and address these concerns via the contractual relationship they establish with the MCOs.

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The Honorable Charles J. Milligan, Jr.  
Deputy Secretary for Health Care Financing  
September 20, 2012  
Page 2

In fact, both the Steering Committee and the consultant engaged last year, suggested several fruitful contractual avenues that addressed the concerns the Steering Committee identified- including what was called a "protected" MLR, to address cost and profit concerns and performance standards that might be crafted to address specific clinical, quality, cost and consumer experience metrics.

The Steering Committee also raised concerns about providers having to deal with multiple, and a possibly expanding number of MCOs- and the administrative burden this would impose. The Department might have addressed these concerns via a similar pathway they developed in the substance abuse benefit arena. That is, working collaboratively with the provider community, stakeholders and the MCOs, establishing a common set of authorization requirements and CPT billing codes. In addition, the Department might have considered requiring, via the revised standards for Option 1, the use of a common electronic interface for provider/MCO interactions (i.e. billing, authorization requests, claims look up, etc.) Admittedly, the latter would be a big lift, but well worth the effort if it lead to truly integrated care.

To quote our August 7, 2012 letter:

Of the three options presented, Amerigroup strongly supports Option 1, the Protected Carve-In of all behavioral health services to the MCOs for enhanced care coordination of substance abuse, mental health and somatic health care services. As a large MCO serving the HealthChoice Program since 1999, we have faced increasing difficulty in serving our members with multiple chronic care conditions and/or co-occurring disorders and the problem will only become worse with the anticipated increase of HealthChoice participants in CY 20104. These members are less likely to seek or maintain care for other illnesses or conditions when the member's mental health care is not coordinated with other health care needs. As a result, this lack of coordination of care results in poor quality and outcomes for the member and at a greater cost to the State. Should this option be chosen, we look forward to working with you through the remainder of Phase 2 and Phase 3 to establish the specifications of the program in a way that supports and sustains the long term partnership Amerigroup has always had with the Department.

Amerigroup's data, as well as data at the federal and state level, clearly indicate the significant and profound impact that mental health diagnoses and substance abuse diagnoses have on the course of multiple somatic conditions- from both a clinical outcomes and cost of care perspective. The Committee has done a wonderful job detailing this very issue in many of the attachments gathered over the past year.

The Honorable Charles J. Milligan, Jr.  
Deputy Secretary for Health Care Financing  
September 20, 2012  
Page 3

So let me just briefly comment on the Amerigroup perspective, based on a review of the claims data of our approximately two million covered Medicaid lives. We compared the relative impact of adding a second diagnostic group to a patient with a pre-existing diagnostic condition. The substance abuse diagnostic group ranks number two in adding to overall medical costs, trumped only by developmental delays. The major mental health diagnostic group ranked number seven.

Another way of thinking about this -- for a given patient with a medical diagnosis, **a secondary diagnosis of substance abuse adds more to the overall medical costs than a diagnosis of any of the following diagnostic groups: cardiovascular illness, cancer, or renal disease** - to name just a few.

And, in a similar fashion, for a given patient with a medical diagnosis, **a secondary diagnosis of major psychiatric illness adds more to the overall medical costs than a diagnosis of any of the following diagnostic groups: diabetes, metabolic disorder, gastrointestinal disorder.**

To separate substance abuse from somatic care, on top of the current bifurcation of mental health from somatic care, is going to make a difficult situation worse. To cite just one example, for the past five years we have repeatedly requested that mental health encounter data be routinely supplied to us so that we might, even within the constraints of the current benefit design, attempt to coordinate with mental health providers who were seeing patients.

For five years the response has been - "we are working on it."

We are still waiting for the mental health encounter data.

To separate somatic care from mental health/substance abuse disorders is, we believe, a step backward. Doing so is a disservice to the State of Maryland, which has a proud record as one of the leaders in health care reform. It will put the State of Maryland out of step with the national trends toward fully integrated benefit designs. More importantly, we believe it is a disservice to the consumers because it sends a subtle but clear message that consumers of mental health and/or substance abuse services are somehow different from consumers of somatic care.

We urge the Steering Committee to give careful thought to their decision.

The Honorable Charles J. Milligan, Jr.  
Deputy Secretary for Health Care Financing  
September 20, 2012  
Page 4

We urge the Steering Committee to stop thinking about 'co-occurring' disorders and start thinking about 'multi-occurring' disorders - that is people with serious complex medical conditions that also have mental health and/or substance abuse disorders.

We urge the Steering Committee to consider how the significant concerns and issues they have so aptly identified in the draft report might be contractually addressed in a truly integrated benefit design- rather than in one that, while moving the fault line, still perpetuates the current bifurcated system.

Based on the verbal comments made last week, by both providers and the Department, it appears that all are in agreement on the need to integrate medical, mental health and substance abuse services. The disagreement, and subsequent choice of Option 2, seems to be around the timeline needed in order to arrive at true integration.

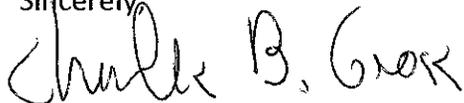
We encourage the Steering Committee to, at a minimum include in the final report, the recognition that Option 2 is a transitional stage, and that the goal, distant as it may seem now, is to arrive at true integrated care.

Amerigroup looks forward to continuing on this journey with the Department, the provider community, and the consumers.

Amerigroup looks forward to participating in Phase 3- and wants to underscore the importance of the RFP, performance standard development, and implementation process. Only by close attention to these processes and work flows will Option 2 be able to successfully bridge the gap it creates between a consumer's medical care and their mental health/ substance abuse issues.

Thank you for your time, hard work, and dedication to the health care needs of the citizens of Maryland.

Sincerely,

A handwritten signature in black ink that reads "Charles B. Gross". The signature is written in a cursive, slightly slanted style.

Charles B. Gross, Ph.D.

Vice President, Healthcare Management Services

cc: Kathleen Loughran, Vice President, Government Relations  
Vincent Ancona, CEO