

Deborah Agus

First, I support the principles enunciated on page 23 but with respect to bullet below, I would encourage a stronger and more specific statement about local management: all local governing authorities should be integrated behavioral health authorities created pursuant to an RFP process outlining responsibilities and expectations.

"Have all components of the publicly-insured behavioral health benefit managed by the same entity."

Second, there should be some attention paid to those who are currently marginalized and for whom expanding eligibility will not be sufficient. In our work through Project Connections, it has been amply demonstrated that there is a significant group of un-served individuals who will not be reached and treated unless there are specialized outreach/engagement/treatment teams embedded in the community to act as front-doors for the traditional clinical systems. Having a community based organization in vulnerable neighborhoods increases ability as well to link with services that impact social determinants of poverty thus laying framework for truly integrated care system.

Third, I think that even in Option 1 which is quite a reasonable approach, there must be some articulation of the differences in needs between those with Serious Mental Illness and histories of psychiatric inpatient utilization and those with diagnoses such as depression/anxiety/trauma. It might be that there be a special MCO for chronic and complex diseases that has a section for that or that there be specialized entity for that SMI population but that includes responsibility for primary care health and linkages as well.

Fourth, I trust that the use of case rate/risk/comprehensive payment balanced by risk and performance outcomes is accompanied by a concomitant reduction in utilization management and bean (or service) counting. Otherwise, the system loses the administrative cost/administrative burden opportunities provided by the case rate thus lessening savings. Additionally, it is inconsistent in principle to encourage creativity and accountability while still micro-managing.

Fifth, why not have a pilot that evaluates direct public financing of the complex provider organization? Or, why not a pilot to evaluate the impact of including for-profit administrative/management organizations?

Sixth, not to mention the elephant in the room but what is happening with dental? For Project Connections clients, lack of access to dental care is an overwhelming health problem leading to exacerbated health problems, exacerbation of emotional problems, added difficulties in finding employment etc. Just yesterday I heard about two cases: in the first a 42yo male with what was a relatively minor heart condition who now has a serious and debilitating heart condition caused by a dental infection and in the second a 20yo male presented with NO TEETH so that he refuses to speak or smile and can't find a job or friends. Many of the clients are missing all or some of their teeth because extraction is the only option. This is a

serious public health issue and must be confronted in developing a comprehensive solution to integrated health care.

Seventh, consider current innovative models such as Baltimore Capitation Project and BHLI Project Connections, as potential pilots for working within new principles on special issues and population.

Finally, I think the report does an excellent job of defining problems and proposing options. Thank you,

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