



JOHNS HOPKINS  
M E D I C I N E

**Paul B. Rothman, M.D.**

*The Frances Watt Baker, M.D. and Lenox D. Baker, Jr., M.D.  
Dean of the Medical Faculty  
Chief Executive Officer*

**Ronald R. Peterson**

*President  
The Johns Hopkins Hospital and Health System  
Executive Vice President*

September 20, 2012

Charles J. Milligan, Jr., J.D., M.P.H.  
Deputy Secretary, Health Care Financing  
Maryland Department of Health and Mental Hygiene  
201 West Preston Street  
Baltimore, MD 21201

Dear Deputy Secretary Milligan:

We are writing to provide comments on the Steering Committee Draft Report, "Recommending an Integrated Model for Medicaid-Financed Behavioral Health Services" (made available on September 10, 2012). We appreciate the considerable effort conducted by the Department of Health and Mental Hygiene over the two years as it worked to identify models for Maryland that incorporate the successes used by other states addressing similar goals for integration, while also acknowledging the unique features of Maryland's health care environment in this new structure. We appreciate the opportunity to provide feedback on this report, and this letter represents the Johns Hopkins response to the Steering Committee's proposed plan.

*The Primary Guiding Principle for the Hopkins' Perspective*

**Our response is based upon what we believe to be in the best interest of the patient.** Optimizing the care of the person to maximize the opportunity for good health and well being across all domains and systems should be the foremost concern and goal with any change in the health care system. We strongly support our State's interest and motivation to see the patient as a whole person, and to move forward with integrated care that ensures optimal health for the patient. We believe that this will be cost-effective, but our advocacy for integrated care is driven because we believe that integrated care is good for the patient. We have an abiding and fundamental interest in taking care of patients and, in this process launched by the State, we will continue to forcefully advocate for changes that are in the interest of people who suffer from medical disorders – and seek to break down barriers that silo mental health, addictions, and somatic conditions.

*Johns Hopkins Commitment to Behavioral Health*

Johns Hopkins has a long history of and a substantial commitment to providing care for persons who suffer from mental health and substance abuse disorders. We operate Community Mental Health Centers on both of our campuses in Baltimore City (Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC)). These services have been in continuous operation since 1968, and have provided mental health treatment to thousands of patients from the local communities surrounding the two hospitals. The patients seen at Johns Hopkins often have the most severe forms of psychiatric

disorders and substantial comorbidities, and our faculty and staff have had a sustained commitment to providing Johns Hopkins quality services to these patients and their families. In addition to these major outpatient operations, we provide other specialty outpatient services for psychiatric patients on both campuses, and maintain a substantial set of inpatient components for the treatment of this patient population (with 108 dedicated inpatient adult psychiatric beds across the two campuses, as well as 12 psychiatric beds for children on the JHH campus).

Both campuses also have a long history of providing a variety of outpatient and inpatient services for patients who suffer from substance abuse disorders. We typically have between 800-1000 outpatients on the JHH and JHBMC campuses who are in some form of active treatment for opioid dependence, and additional patients being treated for other substance use disorders such as cocaine, alcohol, and cannabis dependence. We also provide inpatient services for patients with significant comorbid conditions (dually diagnosed patients), as well as medically supervised withdrawal (e.g., for patients with alcohol dependence).

In addition to the services provided in Baltimore City, the Johns Hopkins programs draw patients from the surrounding suburbs of Baltimore. Johns Hopkins operates inpatient and outpatient programs for psychiatric disorders and/or addictions at Howard County General Hospital, Sibley Hospital, and Suburban Hospital. Our programs – both mental health and substance abuse related – have provided state of the art care to thousands of individuals in the state of Maryland. Johns Hopkins has served as a leading national and international resource in the study and treatment of these disorders while educating professionals from our local community, and from around the world. We want to emphasize that we have been dedicated to the care of our local citizens who have mental health and substance use disorders, and remain committed to providing high quality treatment to these patients while advancing our understanding of the nature of these disorders and the optimal approaches in the prevention and treatment of these conditions. U.S. News and World Reports has ranked the Johns Hopkins Department of Psychiatry as the top such Department in the U.S. for the past two years.

#### *True Integrated Care – Somatic and Behavioral Health Services*

When the HealthChoice system was created, it carved out mental health services but not substance abuse services; the latter were included with other somatic care services. This carve out created a bifurcated system of care that is inefficient and clinically ill suited for the treatment of the patient as a whole person. It runs counter to national trends that have emphasized the importance of treating the whole person, and it perpetuates a perception of mental health disorders as being different and outside mainstream medicine. It fragments care, and places burdens on administrative systems that must find ways to communicate between one body of information (i.e., somatic/substance abuse) and a second body of data (i.e., mental health). The high prevalence of mental health and substance abuse disorders in an aging population suggests that there will be a growing need to have close and coordinated services that address the health care issues of aging concurrent with the behavioral health needs of patients.

**We are forcefully advocating for the adoption of Model 1 in the state's deliberations of integrated health care.** Having the State of Maryland carve in mental health services for the HealthChoice system is a critically necessary step to providing care that maximizes integration of treatment. Systems of payment for health care should incentivize the coordination of care and the treatment of the patient as a whole person. Carving out services (either mental health, substance abuse, or both mental health and substance abuse) has several liabilities. It can create incentives to diagnose a patient with a disorder that then moves the patient to a payment mechanism that provides higher payments or easier clinical reviews and reimbursements. For example, the current system with a mental health carve out creates an incentive to misdiagnose patients with substance use disorders as having a separate mental health disorder. Carve outs can decrease payor incentives to aggressively manage a current disease condition if there are no consequences to the payor for later complications from that condition. For example, under a carve out

system there is no financial incentive to aggressively manage intravenous drug use even if that drug use results in repeated episodes of prolonged hospitalization and morbidity due to infectious diseases.

Furthermore, a system that encourages some behavioral health by primary care providers (PCPs; a group that currently delivers a substantial proportion of non-complicated behavioral health treatment), but then finances other mental health and substance abuse treatment through another mechanism, runs the risk of alienating and marginalizing PCP behavioral health treatment through a needlessly duplicative and complicated system. Finally, coordination of information and data regarding the patient is unduly complicated by having multiple systems of care. Case management services, for example with a pregnant woman who has both a substance abuse disorder and a mental health disorder, can be needlessly complicated with duplicative services – or, even worse, the assumption by different funding entities that some other payor is providing needed services. This is inefficient and, most importantly, **contrary to the best interests of the patient.**

The Draft Report is concerned that Model 1 will be operationally complicated. We believe that any change will inherently involve operational challenges (and opportunities), and that either Model 1 or 2 will produce challenges for providers, managed care entities, and the state. We appreciate that the proposed Model 2 has attractive features, and that it represents less change for a substantial part of the provider community. However, it is striking that the Draft Report does not focus upon the advantages to patients associated with Model 2, but rather the advantages to systems. We want to ensure that the patient is not lost in this discussion, and that changes represent improvements in the care and care coordination of patients.

The concept of integrated systems of health care for patients is not a new approach within the state of Maryland. Systems that use an integrated and coordinated model of care for the whole person already exist and work effectively here. For example, integrated care is a part of the Johns Hopkins Employer Health Programs (EHP), a managed care entity that has over 55,000 covered lives.

#### *Other Considerations – J-Chip and Parity application*

We are also concerned that the State appreciate the potential impact of a carve out of mental health and/or substance abuse on our recently awarded Center for Medicare and Medicaid Innovation grant, Johns Hopkins Community Health Partnership (J-Chip). This is a three-year, \$19.9 million grant that seeks to improve care coordination in the geographical areas surrounding JHH and JHBMC. **An important feature to J-Chip is the active integration of behavioral health and substance abuse services as well as demonstration of sustainability after the initial three-year funding period. An integrated and coordinated payment system is critically needed for J-Chip's success.** Maryland's ability to demonstrate favorable outcomes and be a national model with J-Chip should be of high value and appreciation by CMS, and the State's continued support of this award is much appreciated.

A further concern with the lack of integration of mental health and substance abuse with somatic care is that this lack of integration not jeopardize the success of national parity legislation. Federal parity law would not apply in the case of a risk-based carve out of behavioral health services from somatic care (Model 2), as the parity law applies to Medicaid MCOs but is silent on the applicability to an Administrative Services Organization (ASO) or a Behavioral Health Organization (BHO). Parity was a significant accomplishment by the mental health and substance abuse treatment and advocacy communities, and is an important benefit that holds great potential for ensuring the fair availability of treatment services for those who suffer from these disorders. While we are still awaiting guidance from CMS on the applicability of the federal parity law, there is evidence that the carving out of mental health or substance abuse from Medicaid may compromise the applicability of federal parity legislation. We would strongly advocate that the state take no steps that might jeopardize this important law.

*Conclusion*

We realize that there are members of the mental health community who have concerns that the carving in of mental health services such that MCOs manage these services may risk the funding levels that have historically been available through the state's current system of fee for service funding with an ASO management of resources. We believe this should not be the driving force for decisions by our State Department of Health and Mental Hygiene in a situation where it is contrary to the best interest of patient care. While the compelling reason to integrate these funding streams is to maximize care of the whole person, we also believe that it becomes in the MCO's interests to ensure high quality and appropriate mental health and substance abuse treatment for their members. It will be the responsibility of the state health department as the contracting and regulatory agency for MCOs to adequately monitor MCO behavior to ensure appropriate care.

Coordinating mental health and substance abuse services with somatic services is critically important, given the numerous areas in which these health care domains overlap. We are confident that with proper checks and balances, the State can ensure that there is a fair and proper level of funding for persons who suffer from mental health disorders as well as substance abuse. Maryland has an opportunity to lead the country in demonstrating how integrated care can improve the health of our citizens in a cost effective manner, and we strongly encourage the state to institute a model that achieves the goal of improving the health and lives of persons in our state.

Sincerely,



Paul B. Rothman, M.D.  
Frances Watt Baker, M.D., and Lenox D. Baker Jr.,  
M.D. Dean of the Medical Faculty  
Chief Executive Officer, Johns Hopkins Medicine



Ronald R. Peterson  
President, The Johns Hopkins Hospital and  
Health System  
Executive Vice President, Johns Hopkins  
Medicine

cc: Joshua Sharfstein, M.D., Secretary, Department of Health and Mental Hygiene  
Members, Behavioral Health Financing and Integration Options Steering Committee:  
Patrick Dooley, Chief of Staff & Assistant Secretary for Regulatory Affairs, DHMH  
Brian Hepburn, M.D., Executive Director, MHA  
Laura Herrera, M.D., M.P.H., Chief Medical Officer, DHMH  
Daryl Plevy, Deputy Director, MHA  
Kathleen Rebbert-Franklin, LCSW-C, Acting Director, ADAA  
Tricia Roddy, MHSA, Director of Planning Administration, Medicaid  
Susan Tucker, Executive Director of Health Services, Medicaid  
Members, Senate Budget & Taxation  
Members, House Committee on Appropriations  
Allan Pack, MPA, Budget Analyst, OBA  
Simon Powell, PhD Principal Policy Analyst, DLS