

Government, Community and Public Affairs

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The Honorable Joshua Sharfstein, M.D.
Secretary, Department of Health and Mental Hygiene
Office of the Secretary
201 West Preston Street, 5th Floor
Baltimore, Maryland 21201-2301

RE: An Integration Model for Medicaid-Financed Behavioral Health Services

Secretary Sharfstein:

Johns Hopkins continues to advocate for a patient-centered and fully integrated system of health care and to oppose a system that fragments care with carve-outs. Set against the backdrop of federal and state health care reform efforts, behavioral health integration is an opportunity to expand Maryland's reputation as a national leader in health care reform. Unfortunately, the Steering Committee's recommendation will take Maryland in the opposite direction of health care reform efforts. We urge you to capitalize on national and state momentum to develop an integrated system of care that will improve patient health and experience while reducing costs.

We live in a period of dynamic change in our nation's health care system. The President's vision for innovation-driven reform, coupled with the O'Malley/Brown administration's relentless effort to align incentives in our health care system with outcomes, has led government and health care providers to collaborate in designing a more sophisticated model of care that puts patients first.

During his first term, President Obama articulated a vision for improving the experience of care, improving population health, and reducing the per capita costs of health care. The Obama administration has worked to foster better total patient care through better coordination and reduced reliance on fee-for-service models. Through the CMS Innovation Center, the administration has offered tools and incentives for delivering better care, improving health, and containing cost with systems that are designed to meet patients' needs. The Obama administration has challenged state governments, private payers, and providers across the spectrum to shed old stereotypes about health care financing and delivery, and to look for new and innovative models of patient-centered care.

Over the past six years, the trajectory of health care reform in Maryland has shown the Governor's commitment to expanding access, while containing costs by improving the alignment between the incentives offered to payers and providers with the healthiest outcomes sought for patients. The 2007 Medicaid expansion took Maryland from being ranked as one of the lowest eligibility levels, to a state leading in eligibility levels. Since the enactment of the Affordable Care Act, the State has worked tirelessly to design a Health Benefit Exchange that will be emulated around the nation. With the creation of Health Enterprise Zones, the State took a pioneering step towards integrating patient care to combat disparities, improve outcomes, and generate savings. In discussions on the State's Medicare Waiver, the Department of Health and Mental Hygiene has repeatedly challenged payers and providers alike to look at total patient care. None of these actions represented the path of least resistance. Time and again, the O'Malley/Brown administration has demonstrated that it is prepared for tough fights in order to make sure that patients are front and center in the development of health policy, because the State's policy decisions have a lasting impact on the population that our social safety net is designed to protect.

Recently, you offered the readers of the *Baltimore Sun* a clear vision for building on the foundation that the O'Malley/Brown administration has laid. You made a compelling case for aligning the delivery and payment of health care to bring about better outcomes for patients. You wrote that the government must pay for the value of services, not their volume. You noted that this shift is underway in Maryland, and you resolved that the State has an obligation to move further and faster. Your argument puts you at the vanguard of public health officials who are committed to transitioning our nation's health care system from a fee-for-service payment model to a more sophisticated model that rewards providers for delivering better patient-centered care.

Against the backdrop of the Obama administration's embrace of innovation-driven reform and the O'Malley/Brown administration's demonstrated ability to fight for patient-centered care, behavioral health integration should be an opportunity for Maryland to continue its role as a national leader in health care reform. Unfortunately, the Steering Committee's recommendations run counter to prevailing trends and fail to provide a mechanism for enhanced and comprehensive care for patients. In many ways, the report thinks inside of the existing box for health care financing and delivery in Maryland. As a result, its implementation will exacerbate existing problems instead of solving them. We urge you to think outside of that box, evaluate the State's behavioral health integration in the context of the broader trajectory of health care reform, and adopt a recommendation that will harness the momentum generated by the Obama and O'Malley/Brown administrations to create a fully integrated model for public health officials around the nation to follow.

Johns Hopkins Supports Full Integration

Johns Hopkins participated in each stage of the behavioral health integration process. We attended meetings and submitted comments during the 2011 public process. We attended meetings and raised concerns about the information being shared during the 2012 public process, and we submitted comments in response to the draft report. Copies of our correspondence are attached to this letter.

In our September 20 letter, we advocated for full integration because it is in the best interest of patients. Nothing in the final report changes our position. Optimizing the quality of patient care to maximize the opportunity for good health should be the foremost concern with any change to

the health care system, and our position is based upon what we believe to be in the best interest of the patient. Community mental health providers have concerns about their relationships with managed care organizations, and those concerns can be – and should be – addressed through this process, either by the enforcement of existing regulations or the promulgation of new ones.

In the next section, we outline our general concerns with the report, including its focus on systems instead of patients, its failure to answer threshold questions about clinical objectives, and its failure to incorporate a broad spectrum of stakeholder input. In the following section, we outline several specific concerns with the report, including its treatment of coverage issues for the entire Medicaid population, administrative burdens, relationships with non-medical systems, eligibility churn, and federal parity.

General Concerns with the Report

Johns Hopkins is concerned that the report is focused on systems, not patients. The report focuses on challenges and opportunities for health care providers, managed care organizations, and the State – not on advantages to patients. Everyone involved in the public process – including the Department and its consultant, providers, and health care experts – recognizes that full integration is the “ideal model” to serve patients.¹ We urge you to consider your final decision in light of what is best for patients, not systems.

We are also concerned that the report approached the question of behavioral health integration from the wrong perspective. If the goal was to create a cost-effective patient-centered model, a threshold determination should have been made of what is clinically necessary to achieve healthy outcomes. Decisions about the funding model should flow from that threshold determination, so that financial incentives can be aligned with desired outcomes. The report neglected to make this threshold determination. Instead, it proposes a financing model and leaves critical clinical questions unanswered. As you make your decision regarding a final recommendation, we urge you to think about how the financing model could wrap around patients, instead of how patients and providers will have to wrap themselves around the system.

Finally, we are concerned that the report examines the question of integration primarily from the perspective of community mental health providers and does not reflect the input of such stakeholders, including primary care providers and community substance abuse providers, who will be dramatically affected by carving out substance abuse. We urge you to factor the perspectives of a wider array of stakeholders into your decision.

Specific Concerns with the Report

Coverage for the entire Medicaid eligible population. The report asserts that Model 2 is the only option for covering the entire Medicaid eligible population, and that some patients would not receive behavioral health services under other models. This is inaccurate. For the small percentage of individuals not eligible for managed care, behavioral health could be provided in the same manner that somatic care is currently provided. Options available through the Affordable Care Act (ACA) to improve care coordination for the dual eligible population could also be pursued, including the

¹ Page 13 of the Report states, “Conceptually, stakeholders supported a fully integrated model like Model 1. Some stated that this model represented an ideal toward which Maryland should work.”

Financial Alignment Demonstration program within CMS and chronic health homes. The ACA provides the states with tools to modernize care for the dual eligible population, which suggests that continued reliance on carve-outs to serve that population is contrary to the goals of federal health care reform. In addition, under the ACA, the dual eligible population cannot be excluded from chronic health homes, which ensures that chronic health homes can and will serve as an additional service model for that population.

Burdens on providers. The report asserts that Model 1 “would create substantial administrative costs and burdens for behavioral health providers,” because providers would have to contract with multiple managed care organizations. This assertion does not consider Maryland’s expansion of the Primary Adult Care substance abuse program in 2009. When that was considered, substance abuse providers accustomed to delivering and billing services through the grant system were fearful of moving into a Medicaid delivery and billing system. As the Department reported to the General Assembly in 2010, this transition was successful. This assertion also does not recognize the fact that many providers currently contract with multiple private insurance companies. As a result, the resources and expertise required to contract with multiple managed care organizations already exists within much of the provider community (and will continue for those providers who also deliver services to non-Medicaid patients). The provider community has expressed concerns about managed care organizations that merit Departmental action; all of those concerns can be addressed with the enforcement of existing regulations and the design and implementation of a fully integrated system.

Relationship with non-medical systems. The report notes that individuals with behavioral health needs are often involved in non-medical public systems, including schools, housing, employment and the criminal justice system. The report asserts that Model 2 best integrates the Medicaid-financed behavioral health benefits with these systems. We agree with the need to integrate behavioral health services with other systems, but we disagree that Model 2 is the optimal way to achieve that goal. Under the current system, Core Service Agencies (CSAs) function as the local mental health authorities for planning, managing, and monitoring Maryland’s public mental health system. The CSAs receive state funds to perform these services. If the Department chooses a single ASO with a performance risk contract because a single ASO would be better positioned to communicate with other systems, it follows that State support for the CSAs would no longer be necessary. This would result in CSAs reducing or eliminating services that patients currently rely upon. Johns Hopkins believes that patients with behavioral health needs would be best served under a fully integrated system with the CSAs continuing their responsibility of collaborating with local agencies and organizations.

Eligibility “Churn.” The report asserts that Model 2 is the best vehicle for coordinating the transition of individuals between Medicaid and Exchanged-offered qualified health plans. This is based on the tenuous logic that dealing with two separate systems of care is more efficient than one. Under Model 2, when an individual with Medicaid coverage transitions to the Exchange, they will adjust from having their health care needs covered by one system for physical health and another system for behavioral health, to a system where all health care needs are covered by one entity. Those transitioning from the Exchange to Medicaid will face more challenges since they will be used to navigating one system for all their health care needs, but the transition to Medicaid will force them to use two separate systems to access their somatic and behavioral health services. Johns Hopkins supports the State’s efforts to foster seamless transitions between Medicaid and the Exchange; however, there are better ways to achieve this goal than expanding the existing carve-out. It is

within the scope of the State's authority to include contract requirements for managed care organizations and carriers in the Exchange to develop transition plans. Massachusetts, one of the two states with an operational health insurance exchange, has extensive contract language to help guide managed care organization coverage transitions between Medicaid and the state's Health Connector program.² In addition, National Committee for Quality Assurance (NCQA) has established coverage transition standards for Medicaid managed care organizations that must be met in order for plans to receive NCQA accreditation. NCQA's standards focus on quality improvement and continuity of care in transitions between managed care plans for enrollees with specific conditions.³ Instead of designing a separate system for those with behavioral health needs, Maryland could pursue transition standards similar to those of Massachusetts or NCQA specific to behavioral health services.

Federal parity concerns. After many years of advocacy by behavioral health patients and providers, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008.⁴ MHPAEA requires managed care organizations to provide equal care for somatic and behavioral health services.⁵ The goal of MHPAEA was to ensure that individuals that suffer from mental health and substance use disorders would receive treatment that is on par with other medical conditions. MHPAEA requirements would not apply under Model 2 because MHPAEA applies to health plans and group insurance plans, not ASOs. The current Administration may commit to ensuring that federal parity laws are applicable to Model 2, however, in the future the State or the ASO could choose to reduce behavioral health benefits to achieve savings for the system at the expense of patients. This is a significant deficiency of Model 2 that did not receive adequate discussion during the stakeholder input process. In contrast, MHPAEA requirements would apply under Model 1, which would ensure that all patients served by managed care organizations would enjoy federal parity protections. It would be a disservice to patients and advocates alike who fought for behavioral health parity for the State to select a model that does not include the protections of MHPAEA. Model 2 could expose patients to continued inequity in treatment as it pertains to somatic and behavioral health.

Conclusion

President Obama has been a catalyst for forward-looking reform to the nation's health care system, and his re-election ensures that the country will continue to move forward in this important area, not backwards. The O'Malley/Brown administration has made Maryland a model for implementation of health care reform, and you are widely respected for your commitment to transitioning our health care system from a fee-for-service payment model to a more sophisticated model that rewards the delivery of patient-centered care. Against this backdrop, it is clear that behavioral health integration is an opportunity for Maryland to continue its role as a national leader in healthcare reform. Unfortunately, the recommendations before you will move Maryland in the opposite direction of the reform agendas of the Obama and O'Malley/Brown administrations. The recommendations will protect a fragmented fee-for-service system for behavioral health, at a time when national and state leaders are moving towards patient-centered models of care. On behalf of

² State Health Reform Assistance Network, *Creating Seamless Coverage Transitions Between Medicaid and the Exchanges*, April 2012.

³ *Ibid.*

⁴ 42 U.S.C.A. §300gg-26 (2012)

⁵ *Id.*

the health care providers at Johns Hopkins, I urge you to revisit the report's process and conclusions, and to select a model that aligns incentives with healthy outcomes. In so doing, you can improve the quality of care delivered to thousands of Marylanders, and generate meaningful momentum for health care reform.

Johns Hopkins stands ready to assist you in this effort. We are committed to a fully integrated model of patient-centered care. We respect the concerns raised by many community mental health providers. Their concerns merit action by the Department, either using existing tools or by creating new tools in the legislative or regulatory processes. Given the understanding that full integration is the best model for patient care, and the trend towards integrated care under federal health care reform, we must raise serious questions about a recommendation that moves in the opposite direction. The O'Malley/Brown administration has made great progress in implementing federal health care reform – progress that will save money and improve health care outcomes for some of Maryland's most needy patients. Please take this opportunity to continue that progress, by re-evaluating this report and embracing a model that fully integrates somatic and behavioral health in Maryland.

Respectfully,



Patrick H. Murray
Director, State Affairs

cc: Chuck Milligan, J.D., Deputy Secretary, Department of Health and Mental Hygiene
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