Summary of July 31, 2012 CBH Response to the Maryland Psychiatric Society Statement on Behavioral Health Integration

The Maryland Psychiatric Society sent a letter to DHMH in July 2012 advocating a carve-in of behavioral health services, presumably along the lines of Model 1. The Community Behavioral Health Association of MD emailed MPS leaders to explain the reasons virtually every other mental health stakeholder group has advocated and continues to advocate for a carve-out of behavioral health services from HealthChoice. In addition to countering the allegation that carve-out advocates do so out of a resistance to change (we noted, for example, the many innovative integration projects community mental health providers are conducting across the state as well as stakeholder involvement in the development of health homes), CBH made the following other points:

- The issue is not when and why to integrate, it's who should integrate. Who should direct whole-person care integration?

- While the MPS rationale is honorable in arguing that carve-outs may separate the brain from the rest of the body and can be stigmatizing, MPS was speaking about an ideal world, while we're actually dealing with the real world of for-profit HMOs and MCOs who have a history, at least nationally, of neglecting people with specialized needs and diverting mental health dollars to other services and to profits. CBH's response said: "DHMH has made it clear that HealthChoice MCOs are here to stay, and while their practices may be tweaked with additional regulatory requirements, it would be naïve to think that their overall way of treating individuals with specialized needs will change very much, not because they are evil but because their focus is more acute-care oriented for individuals with more routine conditions. That's why there are carve-outs not only for mental health but for dental care and "rare and expensive case management" (REM) kids among others."

- The charts at the end of the MPS statement are included to support their position but in our view they actually speak to the need to include behavioral health in all care coordination models. This is very similar to the information many consultants have reported in various National Council for Community Behavioral Healthcare materials about how dramatically behavioral health impacts overall health costs -- and why the behavioral health system needs to be the entity that manages whole person services and dollars, not MCOs.

- CBH and other stakeholder groups believe strongly that the only way to ensure ongoing access to mental health services is to preserve the carve-out. We have been and remain concerned that carving mental health services into the HealthChoice MCOs will divert scarce dollars

from services to profit margins, administrative costs, and somatic care. Further, the notion that a carve-in to the MCOs will result in integrated care is contradicted by the fact that most MCOs carve out mental health services to a downstream risk entity, with each layer taking service money off the top.

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Att'd is a CBH position statement. Kentucky may soon be added to the list of carve-in disasters -- CBH learned in late July that state leaders there are looking at reversing a mental health carve-in because community providers are going broke (not even getting paid in some cases) and consumers are losing access and increasing their use of EDs and hospitals.