**Lawrence Epp, Ed.D**

Thank you kindly for the tremendous effort you and your team undertook in composing the report. You have certainly highlighted the great value of integrated care; and you have helped prepare our state for health care reform and a value based care orientation.

My concerns revolve around the empirical support for a capitated system of reimbursement for the chronically mentally ill. I feel at this time there is neither enough empirical support to recommend or discourage it. I suggest if capitation is chosen as a payment method that it be piloted first in a representative group of mental health providers before introduced on a wide scale. This would insure that mental health providers who operate on thin margins would not be harmed by an unforeseen reduction in income or that the treatment capacity of our public mental health system would be inadvertently compromised. I would like to raise the following issues/questions:

1. In making the recommendation of a capitated behavioral health model, what empirical studies were referenced to justify this model over the current fee-for-service model? While in my own research I have come across work by the Lewin Group and academic researchers that point to cost-savings for state public mental health systems, I cannot locate any research that answers what potential financial impact there is on the mental health providers in moving from a fee for service to a capitated system, or whether the transition to such a system would inadvertently reduce treatment capacity or provider numbers. The research on integrated care is exciting and compelling, but that on capitation leaves for me more questions than answers.

2. I wonder if we must seek studies that look at capitation as applied to clinics who service the highest end patients. It would appear capitation works best from a financial perspective when there is a diverse client pool in terms of severity of illness. When there is a high concentration of high end patients, would providers have greater difficulty managing financially under capitation than fee-for-service?

3. In a public mental health system where the median clinician salary is in the low 40s and there is already financial instability, would capitation have a different result here than in the somatic care world that has greater financial insulation? I'd like to know if there is a way to project how a capitation model would impact the average community mental health program financially before embarking on the unknown?
Thank you kindly for accepting this feedback on your report,

Lawrence Epp, Ed.D
Director of School Mental Health Services
Linkages to Learning/GUIDE Program