



November 8, 2012

The Honorable Joshua M. Sharfstein, M.D.
Secretary of Health & Mental Hygiene
Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

**RE: Department of Health and Mental Hygiene Stakeholder Process and
Recommendation on Behavioral Health Integration**

Dear Mr. Secretary:

As you are well aware, on October 1, 2012 a Steering Committee of the Department of Health and Mental Hygiene (Steering Committee) released its final report on Behavioral Health Integration (BHI), which recommended to you a “carve out” financing model for integrated behavioral health services. This recommendation was the result of countless hours of hard work, and involvement from a wide variety of stakeholders who actively participated in the many meetings and workgroups that were an integral part of the BHI study over the last several months.

We commend Deputy Secretary Milligan on leading such an inclusive, open and participatory process and we thank the many individuals who comprised the broad cross section of stakeholders who took action and involved themselves in this important process. Representatives included consumers, families of consumers, providers, Behavioral Health Organizations (BHOs), Managed Care Organizations (MCOs) and advocacy groups. We believe that this high level of participation and transparency led to a well thought out and well-conceived recommendation that addresses the needs of the widest swath of stakeholders in the most cohesive way, while maintaining the focus of developing the best system of care to meet the total health needs of Maryland consumers.

Furthermore, we thank you, Mr. Secretary, for taking the time to thoughtfully reflect upon the implications of this policy and for appointing the subject matter experts within your administration to collect the feedback and propose to you a recommendation that recognizes the best interests of Maryland citizens, the State, and all parties involved.

In addition to explaining the process and providing substantive support for the recommendation of a carve-out model, the document also identified four challenges perceived to be associated with a carve-out model: care coordination; payment disputes; shared savings; and common data platform. We would like to address these challenges to demonstrate how all four represent opportunities for a BHO to demonstrate its capabilities to mitigate each.

CARE COORDINATION

Care coordination is often viewed as one of the major challenges to a carve-out model. Given that mental health and substance abuse often present as co-occurring diagnoses and require the highest level of protected health information, it has indeed been challenging to integrate these two areas of treatment services when provided by separate systems. Therefore, we fully support the recommendation of managing both within one BHO, which has demonstrated expertise with the distinct and specialty services often needed for this population.

The same issues do not arise when faced with the need to integrate the special treatment services for mental health and substance abuse with the somatic services. This can more easily be achieved with some modifications in the expectations specified in the contracts for those MCOs and the BHO serving Medicaid members, for example, requiring timely exchange of pharmacy, laboratory data and provider contact information. We believe that there exist several solid platforms within the current system on which to expand to maximize direct integration between somatic and behavioral health services.

One such platform is the long-standing Coordination of Care Committee, headed by Dr. Gayle Jordan-Randolph which is comprised of key representatives from the Mental Hygiene Administration (MHA), ValueOptions, and administrators from the seven Medicaid MCOs. This committee currently meets every other month to focus on improving communications between all the entities invested in developing and maintaining a coordinated care delivery system. The Committee meetings involve training, sharing data, identifying resources, and addressing themes surrounding the highest cost, most at-risk consumers in both the MCO and Administrative Service Organization (ASO) patient populations.

Historically BHOs, including ValueOptions, have successfully implemented cross system care coordination models in other states irrespective of the financing model.

PAYMENT DISPUTES

Payment disputes, in this context, refer to instances in which both the BHO and MCO have denied a claim, indicating that the other entity is the responsible party. Instances like this, which do occur and can be administratively burdensome for providers, are quite rare in the current system. The Public Mental Health System (PMHS) currently has a cohesive set of payment rules and guidelines in place to assist providers in determining what services should be paid by the ASO versus the MCO (which currently covers select substance abuse services).

The PMHS has a Reimbursement Schedule, a Combination of Service Rules schedule and a PMHS Approved Diagnosis listing (all posted on the ValueOptions Maryland website), which provide guidance to providers as to what services are covered in the PMHS versus services for which the MCOs should pay. As with any system, there are still opportunities for improvement and we are committed to continuing to work with MHA, MCOs, the Maryland Hospital Association and others to minimize any areas which lack clarity within the current system.

SHARED SAVINGS

A long-standing myth associated with the integration of care is the assumption that one payor automatically aligns incentives to create integration via shared savings. In other words, some falsely assert that aligning the payment system under the MCOs equates to care coordination/integration. In fact, the ability to align incentives and share in cost savings between multiple entities can be achieved through the development of shared savings models and performance incentives under the proposed model.

This can be accomplished by, and adapted to, a variety of reimbursement options from capitation to fee for service. It is not necessary to have the costs and savings within the same organization. The key is for the contract to be constructed in such a way as to align the savings and incentives to achieve the desired outcomes. The integration of services at the level of care delivery, not payment, creates alignment of incentives across behavioral and physical health systems.

COMMON DATA PLATFORM

Another common misperception associated with the integration of care is that efficient and effective data exchange is more easily achieved across delivery systems when all providers are enrolled within a single network. However, ValueOptions Maryland currently provides data from within and without the PMHS network to several organizations and state agencies as well as to providers to improve coordination of care and service delivery.

Within the State government agencies, ValueOptions Maryland is actively working with the Department of Public Safety and Correctional Services (DPSCS) to identify recent arrestees that are engaged in the PMHS. DPSCS receives information on open authorizations for care and recent medications. The local Core Service Agencies receive similar information in order to inform the providers and ensure that there is continuity of care.

ValueOptions Maryland also receives a monthly data file that includes all Medicaid Pharmaceutical Claims. This information is available to PMHS providers via IntelligenceConnect and allows them to see up-to-date information regarding consumers in their care.

Additionally ValueOptions Maryland has been providing the Medicaid MCOs with a monthly file containing PMHS authorization information for consumers that are currently enrolled in their respective MCO and has just recently agreed to participate in a pilot sponsored by one MCO to better coordinate care between somatic and behavioral healthcare for a high risk targeted population.

We believe that these four perceived challenges actually provide opportunities for a BHO to further evidence the full extent of their capabilities for integration across multiple delivery systems and State agencies. None of these represent obstacles for a fully integrated system of

healthcare and in no way do they diminish the significant benefits stated in the Steering Committee's recommendation. We are confident the stakeholder-supported recommendation of a "carve-out" financing model, managed by a specialized BHO, will best meet the mental health and substance abuse needs of Marylanders and we urge you to endorse this recommendation on behalf of the Department.

If you should have any questions with regard to this letter, please feel free to contact me at (410) 691-4008 or Marc.Reiner@valueoptions.com.

Sincerely,



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cc: Steering Committee Members