



MedStar Health

December 8, 2011

Ms. Michelle Pringle
Executive Associate for
Deputy Secretary for Behavioral Health and Disabilities
Department of Health and Mental Hygiene
201 W. Preston Street, 5th Floor
Baltimore, Maryland 21201

RE: Future Options for Integrated Behavioral Health Care

Dear Ms. Pringle:

On behalf of MedStar Health, thank you for the opportunity to share our perspectives on the consultants draft report on *Future Options for Integrated Behavioral Healthcare*.

As the consultants note, there are a number of federal policy changes that will positively impact the delivery of behavioral health care services in Maryland. The addition of 380,000 Marylander's with insurance coverage in 2014, implementation of the federal "mental health parity" law, and any mandate for behavioral health in the "essential benefits plan" will all expand the availability of mental health and substance abuse services – especially for those who have depended on public systems and providers

At the same time, the health care landscape is changing and new delivery systems are emerging for enhancing treatment in primary care for improving management of chronic conditions and managing care for special population. Examples include:

- Patient Centered Medical Homes
- Health Homes as authorized under Section 2703 of the Affordable Care Act
- Integrated Delivery Systems for SSI/SSDI Beneficiaries
- Accountable Care Organizations

Our comments related to the specific recommendations are outlined below.

Consensus Emerging on Need for Integration

As many of the attendees at the stakeholder session noted, there has been significant movement on the need for integration of mental health and substance abuse treatment. With "dual diagnosis" the expectation and not the exception, fifty percent of Medicaid beneficiaries with a disability having a psychiatric illness, and per capita health care costs three to four times higher for disabled beneficiaries with co-occurring behavioral health conditions, continuation of separate delivery systems is not in the best interest of the beneficiaries or the state. There is growing recognition that the ability to

comprehensively assess patient needs in one place, have a continuum of services available, work as a team and have access to a single medical record are important to improving patient care and outcomes. Additionally, many substance abuse and mental health providers have been cross-trained, assessment instruments have been refined, and clinical protocols developed to better meet the needs of the dually diagnosed.

For the above reasons, we believe a singular behavioral health benefit package that includes both mental health and substance use disorder services would be both more efficient and clinically effective. We also strongly believe that the behavioral health benefits need to be integrated with the somatic care benefit.

“Protected Curve-In” Holds Promise

As noted, the health care landscape is changing. The new emerging delivery systems all incorporate the goal of integrating the care of the whole person in one comprehensive system of health care services. Continuation of the ASO approach for mental health runs counter to the state’s movement toward integration and the use of risk to incentivize clinical outcomes. In addition, significant changes to the ASO contract would be needed to include substance abuse services and the transition would likely disrupt the gains in access to substance abuse services under the PAC expansion.

In January 2010, the Department strengthened its commitment to substance abuse treatment through three initiatives: 1) increasing reimbursement rates to Medicaid providers; 2) expanding the benefit package of the PAC program; and, 3) improving the ability of enrollees to self-refer for services. As a result of these initiatives:

- Medicaid expenditures for outpatient substance abuse increased by 74 percent;
- MCOs paid for more than 400,000 substance abuse treatment encounters – a 70 percent increase; and
- The numbers of Marylanders receiving substance abuse services through Medicaid continues to increase – from 17,995 in FY 2009 to a projected 38,697 in FY 2012.

In addition to these gains in access there are several other positive outgrowths from the PAC expansion. As the Department’s recent report to the legislature on the PAC expansion illustrates, the department significantly strengthened its ability to track MCO performance on the provision of substance abuse treatment services, the MCOs were able to successfully expand access, and a targeted/concerted focus on a specific initiative within the Medicaid program works.

With the current environment moving towards more care coordination and integration and the and positive experiences of the substance abuse expenditures outlined above, we believe Option 1, a “protected carve-in,” holds promise. The Department’s ability to perform the necessary data collection and monitoring associated with the PAC expansion could be built upon to allow the Department to provide a separate and dedicated behavioral health capitation payment and ensure MCO accountability for the delivery of behavioral health services. This hybrid approach could essentially be used to balance access protections with the benefits of integration.

It will be critical, however, to ensure that any dedicated behavioral health capitation rate does not create unrealistic administrative burdens for both DHMH and the MCOs or create problems associated with shifting categorization of services provided. And, the MCOs will continue to need the ability to contract with appropriate entities/providers that have expertise in the delivery of behavioral health services.

Lastly, the draft report is unclear on a number of issues related to the “protected carve-in” approach that will need additional detail before we are able to comment, including:

- What is meant by a “strong performance- based selection process?
- What degree of control over MCO management systems is envisioned?
- How would MCOs have the ability to manage the care of the uninsured population?

Selective Contracting Problematic

The draft report contains a number of references regarding the HealthChoice program moving to a “selective contracting” approach. We were confused and concerned about the introduction of this topic into a discussion focused on the integration of behavioral health care and thought the selective contracting discussion was supposed to be at the Medicaid Advisory Committee.

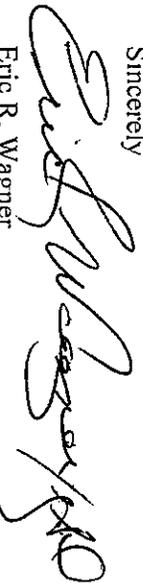
As we have communicated previously, we do not believe that selective contracting would actually further the department’s stated goals of increasing quality of care, holding MCOs accountable for quality and access, and ensuring enrollee’s interests are pursued as Medicaid expands and the Exchange launches. Moving to a selective contracting approach would:

- Consume several years of significant time and resources from all stakeholders;
- Cause unnecessary disruption at a time when program stability is critical;
- Divert resources needed to address more pressing issues associated with federal health care reform; and
- Ignore existing mechanisms in place that could be used to achieve the stated goals.

For the record, attached are the two previous comment letters on this issue that provide further details on our perspective.

Thank you for the opportunity to comment on these important policy issues.

Sincerely,



Eric R. Wagner
Executive Vice President
External Affairs & Diversified Operations

Enclosures



MedStar Health

October 10, 2011

Ms. Tricia Roddy
Planning Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Re: Selective Contracting

Dear Ms Roddy:

On behalf of MedStar Health, this letter is written to share our perspective and serious concerns with the concept currently under discussion to move the HealthChoice program to a selective contracting approach.

As you know, in 1995, MedStar Health chose to participate as a provider sponsored MCO in the Health Choice program to ensure our ability to continue to meet the needs of our communities and support our teaching mission – including training provided in outpatient clinics. We consider ourselves as partners with the state and for over 15 years have worked cooperatively with the state as issues have emerged and priorities have changed. As a result, quality has improved, costs have been contained, expansions have been accommodated, and the program is stable.

Today, MedStar Family Choice has over 29,000 enrollees, operates extensively in Baltimore City and Anne Arundel, Baltimore, and Harford counties, and has received numerous state and national awards in recognition of the quality of care provided.

We absolutely agree with the Department's stated goal to expand coverage statewide and to underserved areas with the promise of better quality of care and oversight. We do not believe, however, the selective contracting approach will actually further those goals. It is more likely that changes of the magnitude necessary to convert to a selective contracting approach would be detrimental to the program and the enrollees who rely on it.

Our specific concerns with the selective contracting proposal include:

Major time/resource consuming endeavor –

Moving to a “selective contracting” program would consume several years of significant time and resources from all stakeholders. The selective contracting process for the (much smaller) dental program took several years to become operational. And, with the budget reductions at

DHMH over the intervening years, it is unlikely the Department is able to handle the work within existing limited resources.

It is very different for a state to adopt a selective contracting approach at the outset of the program verses creating wholesale change 15 years into what is considered a stable program today. In Maryland, the disruption would impact more than 800,000 enrollees and create unnecessary chaos at a time when stability is needed most.

Furthering the participation of ‘provider sponsored’ MCOs like MedStar Family Choice, was a core component of the 1996 legislation and one of the key factors in the ultimate adoption of the mandatory managed care approach. We believe selective contracting, coupled with a requirement that the selected MCOs participate as a commercial carrier on the health benefits exchange, could eliminate most if not all the current provider sponsored organizations. And, if that were to occur, it would be a significant step backward from Maryland’s successful program.

Stable platform for 2014 expansion critical –

The Department estimates an additional 175,000 individuals will be added to Medicaid program in 2014 as a result of the federal Affordable Care Act. Locally owned provider sponsored MCOs were the ones that absorbed the largest segment of the recent Medicaid expansion populations. The State and its MCO partners now have the experience and “lessons learned” to make the projected 2014 expansion a success. It would not be prudent to disrupt the HealthChoice program at a time when we’re all preparing for the 2014 expansion.

Other state priorities more critical –

At this juncture, there are several more pressing issues the Department needs to address, including: implementation of a new eligibility determination system, creation of a health insurance exchange, the future sustainability of the Medicaid program, behavioral health integration, reforming long term care, and updating the Medicare waiver. The effort required to implement selective contracting would divert scarce resources necessary to address these critically important issues.

Other ways to achieve stated goals –

DHMH was prompted to seek public input on this proposal as one strategy “to increase the likelihood of coordination between the Medicaid MCO market and the Exchange commercial market.” There may be more effective ways, however, to enhance this coordination between the Medicaid program and the Exchange without disruption of 800,000+ enrollees. The creation of a “Medicaid look-like” plan to cover individuals between 133%-200% of FPL is one such alternative that should be seriously considered.

I would also note that, over the 15+ years of the program, the state’s MCO partners have repeatedly stepped up to the plate to improve quality, adjust to budgetary constraints, accommodate enrollment expansions, etc. Attached are several charts detailing a sampling of the quality improvements Maryland’s Medicaid MCO’s have made over the last several years. It

is clear from the data that the department's other stated goal of improving quality and oversight can be successfully achieved under the program's current structure.

Medicaid and state employee health benefit plan contracting process not comparable –

While some have articulated the benefits of the RFP process utilized for the state employee benefit program contract, that program is very different from the HealthChoice program. The state employee health plan is predominately a TPA arrangement and not a full risk contract; it is not a federal entitlement program; it does not have the long standing relationship with the Department to adjust to changing priorities; and, is not routinely subjected to the same scrutiny and oversight. In addition, as a 'procurement,' the various components of the state health plan have been subject to numerous bid protests, contract claims, and other disputes that are typical of the 'selective contracting' model.

Experience in other jurisdictions not favorable –

Finally, the attached chart compares the Maryland HealthChoice program with the selective contracting states identified by the Department across several key quality measures. As is evident, Maryland's MCCOs have consistently outperformed the selective contracting states on these important measures.

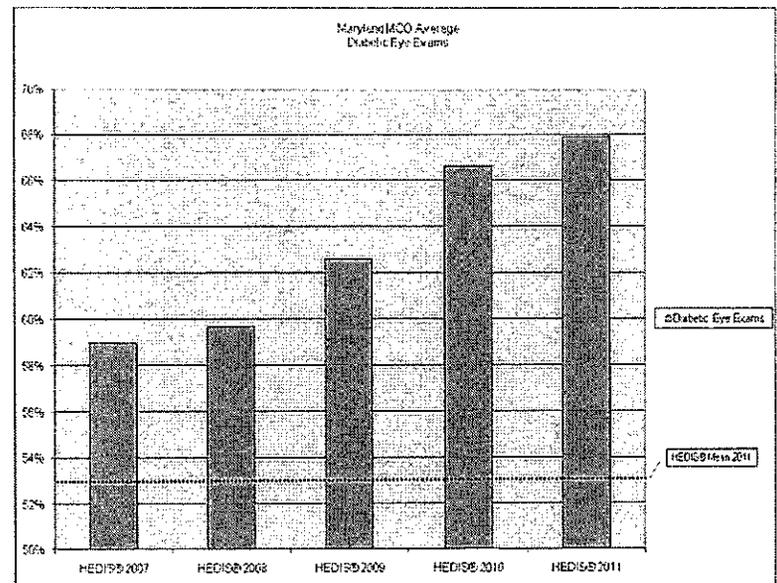
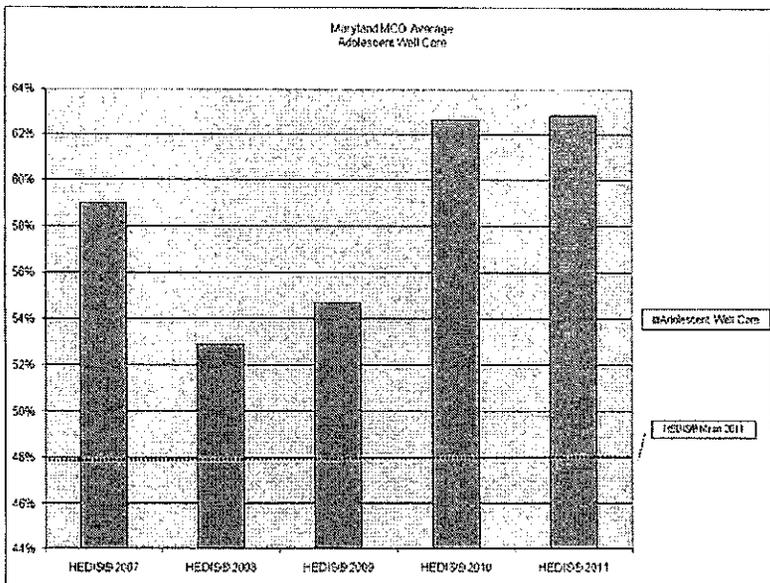
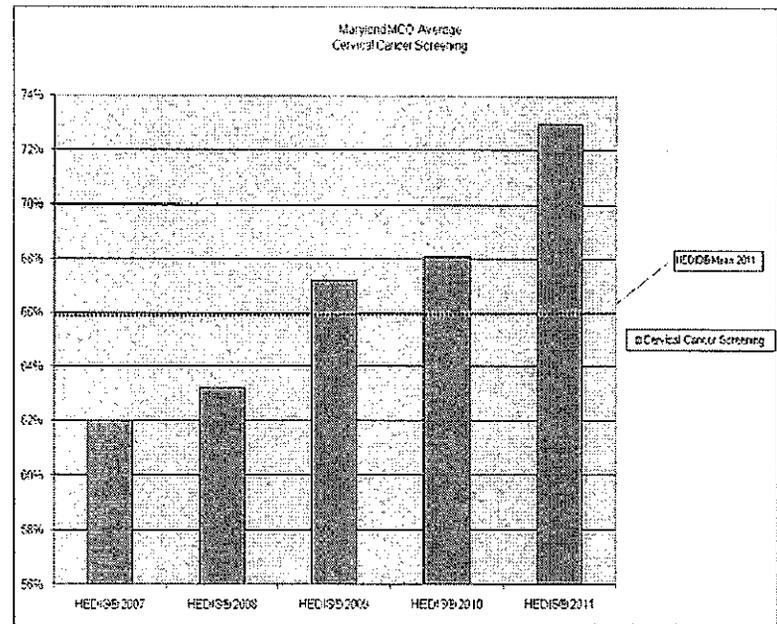
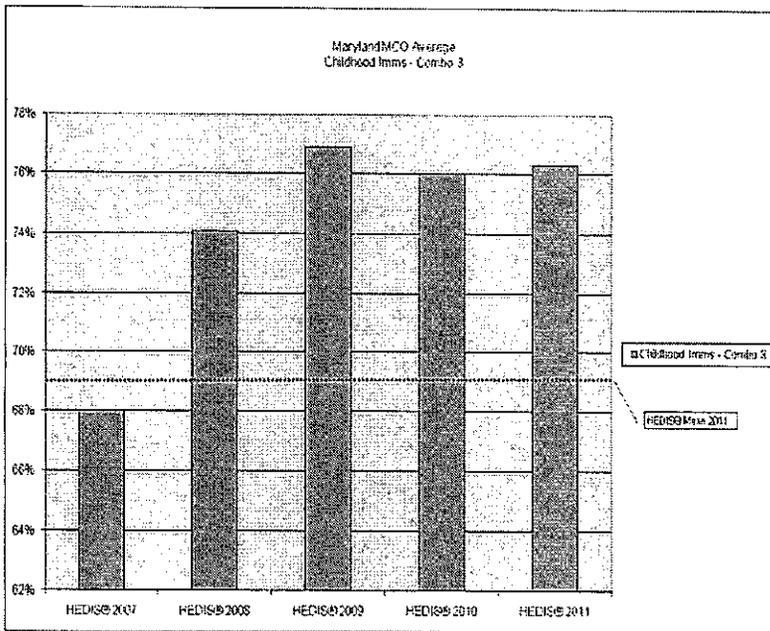
Thank you for the opportunity to share our perspectives. If you have questions or would like to further discuss, please do not hesitate to contact me.

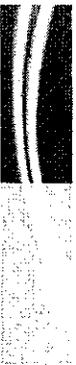
Sincerely,



Eric R. Wagner
Executive Vice President
External Affairs & Diversified Operations

cc: The Honorable Thomas V. Mike Miller
The Honorable Michael Busch
Members, Senate Budget and Taxation Committee
Members, Senate Finance Committee
Members, House Appropriations Committee
Members, House Health and Government Operations Committee
Kevin Lindamood, Chair Medicaid Advisory Committee





MedStar Health

Eric R. Wagner
Executive Vice President
External Affairs and Diversified Operations

November 21, 2011

Ms. Tricia Roddy
Planning Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Re: Selective Contracting

Dear Ms. Roddy:

On behalf of MedStar Health, this letter is written to share our perspective on the most recent issue paper released by the Department of Health and Mental Hygiene regarding options for changing the purchasing strategy for HealthChoice managed care organizations.

We agree with the Department's goal of increasing quality of care in Maryland, to hold managed care organizations accountable for quality and access, and to ensure enrollees' interests are pursued as Medicaid expands and the Exchange launches. However, as you know from our previous correspondence on this issue, we do not believe a selective contracting approach will further these goals. Moving to selective contracting would consume several years of significant time and resources from all stakeholders; cause unnecessary disruption at a time when program stability is critical; and divert attention from more pressing and significant issues that must be addressed to prepare for the 2014 Medicaid expansion. As we noted in our previous letter, other mechanisms exist to achieve the stated goals.

With regard to the three options outlined in the most recent paper, we generally support option #1 – improving HealthChoice utilizing the current regulatory process. We believe the approach outlined for option #1 would best meet the stated goals of DHMH, but more importantly would best meet the needs of HealthChoice enrollees. Over the 15 year history of the program, there have been many regulatory changes made to increase quality, improve access, and contain costs. The program has matured and improved as a result of these changes. This is particularly evident in the area of quality where the metrics are strengthened each year to ensure there is continued quality improvement by the MCOs. This is not a static program but rather one that is continuously evolving to better address the health care needs of the enrollees.

Within Option #1, we offer the following comments intended to strengthen specific aspects of the proposal:

1. *Incorporating More Incentives for Quality* – As noted earlier, quality enhancement is a strategy that has been successfully pursued over the 15 year history of the program and we support its continuation. In fact, the Department is currently proposing regulations to increase the incentives/disincentives for value based purchasing and, if approved, will be effective for measurement year 2012. We are concerned, however, about the methodology used by the Department to establish the quality targets. In our view, the targets should be set using a methodology that is proven to be statistically sound. Together with other MCOs, we have expressed our concerns regarding the current methodology and have requested DHMH to look at how other states set targets. To date this issue remains unresolved. The incentive value associated with reaching targets is diminished if the parties do not believe those targets are attainable.

We are supportive of the concept contained in option #1 that would modify the auto-assignment algorithm to favor higher quality plans. This would serve to both improve the quality of care provided by the MCOs and the quality of care enrollees are afforded.

2. *Streamlining the Application Process* – MedStar Health is supportive of the proposed “open application window” for MCO entry into the HealthChoice program. This would create a more organized process for reviewing and determining MCO participation and could be aligned with other annual program activities and changes.
3. *Adjusting Regional Participation Requirements* – DHMH proposes the reduction of service areas from 40 local access areas to either 10 regional access areas or three rate setting regions. We have concerns regarding the potential impact of this shift, as it may have the unintended consequence of reducing the overall service area of some existing MCOs who may lack network adequacy in the larger regional areas. Our concern might be mitigated if the boundaries used to define some of the regional access areas could be revised to reflect more natural referral areas.
4. *Decision for Serving New Enrollees* – The DHMH proposes that MCOs be required to commit to participating in a defined region for a longer period of time than contemplated under current circumstances. In contrast, MCO rates are set on an annual basis. We believe there need to be safeguards in place to allow an MCO to freeze its enrollment if certain financial triggers occur, based on results of the annual rate setting process and/or state budget reductions to the Medicaid program. In addition, locking the MCOs into longer term commitments brings some network adequacy concerns. As Medicaid expands over the next several years, provider networks need to be able to serve the additional recipients. If MCOs are unable to secure additional provider contracts to meet network adequacy requirements, or if there is a loss of a large contracted provider group in a

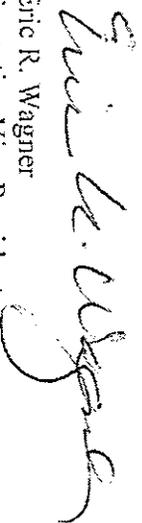
Ms. Tricia Roddy
November 21, 2011
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geographic area, there should be the ability to freeze new enrollments while the MCO addresses those concerns.

For the reasons outlined in our earlier letter, we do not believe that either option #2 (selective contracting) or option #3 ("hybrid" strategy) reflect appropriate directions for DHMH to pursue for the HealthChoice program. Option #1 would allow Maryland an opportunity to attain its legitimate policy interests for the program while protecting the stability of HealthChoice.

Thank you for the opportunity to comment on this very important topic. We hope these comments, in addition to those we initially submitted, are helpful as you consider next steps. We look forward to continuing to work with DHMH on this issue.

Sincerely



Eric R. Wagner
Executive Vice President
External Affairs and Diversified Operations

cc: Mr. Charles J. Milligan, Jr.
Ms. Peggen A. Townsend
Ms. Lesley Wallace