



Robert R. Neall
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December 8, 2011

The Honorable Renata Henry
Deputy Secretary for Behavioral Health and Disabilities
Department of Health and Mental Hygiene
201 W. Preston Street, room 532
Baltimore, Maryland 21201

Dear Ms. Henry:

I am writing in response to the Consultant's Draft Report entitled "Future Options for Integrated Behavioral Healthcare" posted December 5, 2011. Priority Partners and its provider sponsor, Johns Hopkins HealthCare LLC, share the Department's goals of removing barriers to care, integrating the care of the "whole person" under one comprehensive system and simplifying the availability of services for patients who suffer from both mental health and substance abuse disorders.

Priority Partners manages the largest Medicaid MCO in the state, currently over 200,000 lives. While we strongly believe in full integration of behavioral health services given our focus on patient centered care, our specific comments and concerns with the Consultant's Draft Report on options for the integration of Behavioral Health are addressed below. The comments are made in the order in which the issues appeared in the Department's report, not in order of priority.

Option #1

Priority Partners agrees with the recommendation that the comprehensive benefit package including behavioral health, medical and substance abuse benefit be managed by the Medicaid Health Plans/MCOs (i.e. "protected carve-in"); however, we do have concerns with some of the changes suggested in the Consultant's report.



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Recognizing the need to ensure that funding for behavioral health services is well spent on treatment and recovery support, we believe that mandating a separate, dedicated behavioral health capitation rate will in fact create significant administrative burdens for both DHMH and the MCOs and creates the potential for cost shifting and issues with categorizations of services. We believe that the current rate setting methodology and financial reporting systems and processes should be utilized to define the behavioral health component of the total capitation. Modifying the existing rate setting system to ensure appropriate funding for behavioral health services, including the provision of expanded case management and social work support services as well as monitoring MCO performance on a more real time basis would be significantly preferable to creating a parallel, separate process that in our view is not consistent with the stated goal to integrate funding as well as treatment.

Priority Partners also believes that further clarity is needed related to behavioral health network requirements, including but not limited to the following:

- For statewide MCOs, what will be the expectations related to network adequacy requirements as they relate to the MCO's ability to remain open to new enrollment statewide?
- Will behavioral health be considered a "self-referred" service, similar to substance abuse services? If so, what measures will be available to MCOs to ensure that the behavioral and substance abuse services being provided to our members are appropriate and meet quality standards and expectations?

While not specifically mentioned in the Consultant's report, access to care within the HealthChoice program would require enforcement of the current network adequacy standards and changes to the network adequacy regulations to include behavioral health and substance abuse services. The Department's current requirements for network adequacy are geographic rather than related to a provider and membership ratio and currently only cover somatic providers. Network adequacy should better reflect the health needs of the population each



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MCO serves and should be consistently monitored to assure that MCOs are not manipulating their networks to avoid access and therefore avoid risk.

In addition, Priority Partners believes that the recommendation that the behavioral health benefit for the uninsured and for services covered through State/block grant funded programs needs much further definition and we do not believe that this would be the best option for the Medicaid Program at this time.

Option #2

As stated above, Priority Partners is in favor of the "protective carve-in" detailed under Option 1 and would be opposed to having the Medicaid behavioral health benefit managed through a risk-based contract with a separate Behavioral Health Plan (BHP). We do not believe that this type of structure will successfully integrate behavioral health, substance use disorder and somatic services as part of a comprehensive benefit package for the Medicaid Program. However, we would agree that this option should be further explored as an option to administer the behavioral health benefit for those who are uninsured or receiving services through a State/block grant funded program.

On behalf of Priority Partners, we appreciate the opportunity to share our comments on the Consultant's most recent report, "Future Options for Integrated Behavioral Care". We look forward to partnering with the Department as we work together to strengthen the



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HealthChoice program in a way that improves the delivery of health care services to Maryland's Medicaid population.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert R. Neall", written over a circular scribble.

Robert Neall
Chief Executive Officer
Priority Partners

Cc: Josh Sharfstein, M.D., Secretary, Department of Health and Mental Hygiene
Brian Hepburn, M.D., Director, Mental Hygiene Administration
Thomas P. Cargiulo, Pharm.D., Director, Alcohol and Drug Abuse Administration
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