November 1, 2004

Managed Care Liaison Committee
C/o Psychiatric Society of Virginia
P. O. Box 7156
Richmond, VA 23255-1656

Dear Managed Care Liaison Committee:

I am now in receipt of your letters dated March 25, 2004, July 20, 2004 (the original letter I received about SBHS's fee schedule was dated July 20, 2004, not July 6, 2004, as in the enclosure with the October 25, 2004 letter, although I do not believe there is any difference in content), and October 25, 2004. As you requested, I am responding on behalf of Sentara Behavioral Health Services to the concerns raised by the Committee. I will respond to the issues as elaborated in the letters and then would like to make some suggestions as to how we might continue a dialogue going forward.

Before proceeding, a brief clarification on a point made in your letter from October 25, 2004: in addition to the contact I made with then PSV President Gregory Fisher, MD, on April 10, 2004, via both email and phone, I also initiated contact with the current PSV President, Yaacov Pushkin, MD, shortly after receiving the July letter and made arrangements to meet with him to discuss the issues raised in the letter as well as other areas of mutual interest. Subsequently, and prior to our scheduled meeting, he told me he would prefer to receive my written response before meeting face to face, to which I agreed. I hope once this letter is received that we may be able to proceed with a more direct dialogue. I mention this bit of history here because I think it is important that the PSV membership not have the impression that I have been unresponsive to the concerns of the Committee.

First I'd like to direct my comments to the issues raised by the Committee in the letter of July 20, 2004, starting first with the statement that "the level of your fee schedule remains woefully inadequate." It certainly troubles us that even with the revision in our fee schedule, the Managed Care Liaison Committee finds that the current fee schedule is still not acceptable. The revised commercial fee schedule, which became effective in July of 2004, constitutes an overall increase in psychiatrists' fees of approximately 16%, based on an analysis of those CPT codes used most often by psychiatrists, specifically 90801, 90862, and 90805. In fact, the CPT code most often utilized by psychiatrists, 90862, underwent a 25% increase. SBHS has always strived to ensure that our fee schedule for all disciplines is fair, balanced and represents equitable reimbursements for its panel of providers while at the same time remaining competitive with those of other managed behavioral health care organizations with significant business based in Virginia.

In the months prior to the current revision, we extensively analyzed the fee schedules of other Virginia based behavioral healthcare organizations and formulated our fee schedule to be competitive with them. Having conducted this due diligence, we believe the most recent revision of our Commercial and Medicaid fee schedules are reflective of current local market and competitor reimbursement levels.

Since your letter indicates that our current fee schedule is "out of line with fee schedules provided in *other states* (emphasis added) for similar services", we wonder if this perspective on the part of the Committee may explain, at least in part, the difference in perception of the adequacy of our fees. We are well aware that there are fee schedules in other parts of the country whose rates of reimbursement exceed ours. For example, we have no doubt that our current fee schedule is lower than those of MBHOs with business based in New York City or Boston. We feel sure the Committee is aware that throughout health care, fee schedules vary remarkably across different parts of the country and, more to the point, different healthcare markets. This is analogous to and in part driven by the wide regional variations in housing costs, levels of employment income for the same job, and so on.

Since it has always been SBHS's stated intention to remain competitive with Virginia based managed behavioral healthcare companies' fee schedules, we are very interested in and would welcome the Committee's forwarding us other such fee schedules. We are particularly interested if the Committee is able to document instances where our fee schedule is, in fact, not competitive with those of other current Virginia based managed behavioral healthcare companies.

Regarding the second point in your letter, we regret that the Committee has apparently inferred from our fee schedule that we intend to devalue psychiatric psychotherapy or that we do not value psychiatric psychotherapy. We believe this is an unwarranted inference and is not supported by an objective review of our fee schedule. In point of fact, every CPT code reimbursement for psychiatrists is higher than any other discipline (except for family therapy and group psychotherapy) and in no instance is it lower. It is difficult to understand how this can be construed as a "devaluation" of psychotherapeutic services performed by psychiatrists.

In regards to your comments about the practice expenses that fall more heavily on psychiatrists than other mental health disciplines, particularly the rising cost of malpractice insurance, we are well aware of these pressures. In fact, this is part of what led to our providing a substantial increase in reimbursement for those services which, in fact, constitute the bulk of psychiatric practice across the State of Virginia.

The Committee's letter raised questions regarding the rationale for raising the fees of psychologists and masters prepared mental health professionals in the way that we did. SBHS's evaluation of recent data and market information indicated that both the Masters and PhD disciplines were lagging at several levels of reimbursement. Each discipline level was evaluated independently in a fair and balanced approach based on all available

market criteria. As a result, the overall percentage of reimbursement increases by discipline levels differed based upon specific CPT codes and the respective discipline.

In regards to the last paragraph of the Committee's July, 2004, letter, we are aware that nationally there has been a trend for psychiatrists and physicians in general to stop participating on panels of MCOs and MBHOs. I think it is fair to say that Sentara Behavioral Health Services has always valued the critical role that psychiatrists play in our network, and it would not be an exaggeration to say that psychiatrists constitute the lynch pin of our network. We have four practitioner advisory boards across the state, all of which have significant psychiatric representation. Practicing psychiatrists are a vocal and critical component of our Credentialing Committee and our Medical Care Review Committee, as well as our continuing education programs which we provide four times a year across the state. All of our employed psychiatric physicians as well as our physician advisors are Virginia based, have spent many years practicing psychiatry in the State of Virginia and have extensive connections within the psychiatric community.

In short, even if we have not always agreed, we have always valued our open dialogue with Virginia psychiatrists. We are at a loss, therefore, to understand how the Committee would entertain the possibility, as articulated in the final paragraph of the letter, that SBHS's "hidden agenda" is to deprive MCO patients of high quality specialty care.

Let me now turn my attention to the concerns raised in the Committee's letter of April 7, 2004 regarding management of psychiatric formulary issues. Before I do this, however, several points of clarification are in order: first, Sentara Behavioral Health Services has no authority over the pharmacy and formulary decisions of the managed care organizations which retain our services. That said, we <u>are</u> in a position to advise, consult, and influence our managed care partners regarding formulary decisions around psychotropic medications. In fact, we do this in an ongoing way, both formally through participation in the Sentara Health Plan's P & T Committee, and informally through a dialogue with the health plan medical directors, pharmacy staff, committee members, etc. In addition, the P & T Committees of both Sentara Health Plan and Southern Health Services include a community based psychiatrist. More to the point, I have shared the letter of April 7th with appropriate staff at Southern Health Services and have been in dialogue with them around the issues raised by the Committee (more on this below).

Second, there are a number of references, including the statements below in quotes, attributed to me or my organization, for which the origin is unclear. Specifically, the letter states:

- "…your practice of denial of doses of Lexapro over 20mg per day….". SBHS does not review pharmacy requests for Southern Health members and, while we do perform this function for Optimahealth, I am aware of no instances in which we have denied such a request.

- "your evocation of 'evidence based medicine' as a justification for inadequate treatments of patients is flawed by the reality…". Again, I do not know what "evocation" is being referred to here and would appreciate clarification of this ambiguous attribution.

Third, we appreciate the Committee taking the time to articulate the distinction between a pharmaceutical company applying for FDA approval for their drug and a practicing psychiatrist using that drug to treat actual patients in clinical practice. Your points regarding the role of the FDA, the basis for pharmaceutical companies decision making, and the difference between response and remission are well articulated, sound, and I agree with them. In point of fact, our health plan customers consider a far wider range of information in their formulary decision making than FDA indications, and, in my experience, perform extensive reviews of the clinical literature before reaching their conclusions. In short, they want their formulary decisions to be evidence based, not just FDA based.

This leads, in a fairly direct way, to a discussion of the issue of dosing over the FDA limit, in particular with escitalopram. We believe the argument regarding the need to occasionally dose above FDA limits to achieve the optimal treatment response is a legitimate one and one which we are in ongoing discussions with our health plan customers. Because of the key role in health plan formulary decision making played by reference to the evidence base, I myself have spoken on several occasions to clinical researchers and staff affiliated with Forest as well as conducted literature reviews looking for any documentation of the additional benefit of, when appropriate, dosing escitalopram beyond 20 mg per day. While I have not found any literature in this regard related to escitalopram, I have found several articles related to the potential benefit, particularly with more chronically ill depressed patients, of higher dose antidepressants, and have included these in my discussions with our health plan medical directors. If you know of such evidence, or reference to the general issue in clinical practice guidelines, please forward it to me so I can include in future discussions with the health plan medical directors.

In that vein, let me say that MCOs are in the often difficult position of trying to ensure appropriate use of premium priced psychopharmaceuticals, trying to strike a balance between helping to ensure optimized patient response and staying within a pharmacy budget. Health plans have a legitimate interest in ensuring that limited healthcare dollars are spent on treatments of demonstrated value, making formulary decisions on the basis of safety, efficacy and price, in that order.

One last response to specific points raised by the Committee. In the most recent letter, the Committee asks that, in light of the fact that neither I nor SBHS have direct authority over formulary decisions, the Committee would like to be able to communicate directly with the appropriate health plan medical directors. While this is an option, I would make an argument for the benefit of working with me and SBHS as intermediary for most of these issues. For example, I understand that just within the last week or so, some significant headway was made between a PSV member and one of our health plan customer medical directors over the dosing range issue. This conversation has already resulted in the development of draft criteria for approval and plans for future collaboration. As I believe was pointed out in that conversation, the health plan's willingness to reconsider their position was in no small part due to my continued dialogue and persistence with their medical director around this issue.

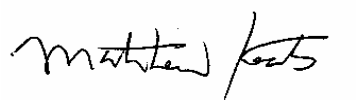
In summary, I'd like to say that no single letter can do full justice to the issues raised in the Managed Care Liaison Committee's letters, nor can letters substitute for having a real dialogue about these matters. As I did with both the current and past PSV Presidents, I reiterate the interest and availability of myself and other appropriate representatives of SBHS to participate in a constructive dialogue with appropriate fellow members of the PSV to explore ways to address the Committee's current and future concerns. SBHS and I believe strongly that we have potentially many more areas of mutual interest with the PSV than of conflict, if we so choose. Just to mention a few such areas:

- we are in the process of developing a document to help provide guidance to psychiatrists regarding the monitoring of patients on atypical antipsychotics for development of the metabolic syndrome
- we are very concerned about the reemergence of the psychiatric bed crunch in the last several months and have already had conversations with several psychiatric and medical surgical hospitals as well as community service boards about potential ways we might participate in some solutions
- we have developed programs to provide intensive care management to our sickest enrollees that can be a significant resource for psychiatrists struggling to treat these patients
- we have developed guidelines just recently distributed to hundreds of Ob Gyn physicians to help them more effectively manage patients with antenatal and postpartum depression so that moms that need to stay on an antidepressant aren't inappropriately discontinued.

We believe these are areas of great mutual interest and we would value the input of the PSV to help make these and other initiatives more relevant and effective, as well as identify other areas where we might collaborate.

As I have already said, I would welcome a more direct dialogue. Toward that end, would you please contact my Assistant, Eileen Ballance, at 757 552-7181, so that we can move forward to the next step.

Collegially,



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