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DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

December 9, 2019

The Hon. Delores G. Kelley, Chair
Senate Finance Committee
Miller Senate Office Building, 3 East
Annapolis, Maryland 21401

The Hon. Shane E. Pendergrass, Chair
House Health and Government Ops. Committee
House Office Building, Room 241
Annapolis Maryland 21401

Re: **Medicaid – Managed Care Organizations – Behavioral Health Services** (House Bill 846 / Senate Bill 482; House Bill 938 / Senate Bill 975; and House Bill 941 / Senate Bill 976 of 2019)

Dear Chairs Kelley and Pendergrass:

The Maryland Department of Health (MDH) would like to provide an end of year update on our behavioral health system of care efforts since our last reports, dated July 25, 2019 and June 5, 2019, respectively. We thank you, other key committee members, and your committee's staff for your time and attention to this matter. We especially wish to thank each of the stakeholders who have participated in this process, in our workgroup, and discussion groups.

As you know, MDH is preparing an in-depth briefing on this topic for tomorrow, December 10, 2019 at 1 p.m., before the full House Health and Government Operations committee.

Attached please find a high-level powerpoint summary of our work, which we will discuss with the House committee, as well as a more detailed report with appendices. All of our behavioral health system of care materials, including meeting notes, can be found on our website: https://mmcp.health.maryland.gov/Pages/BH-System-of-Care.aspx

If you or any other committee members would like committee-level or individual briefings on this subject, we will be happy to accommodate your request. Please do not hesitate to contact me or Webster Ye, Director of Governmental Affairs at 410.767.6481 or webster.ye@maryland.gov if you have any questions.

Sincerely,

Robert R. Neall
Secretary

Attachments: Powerpoint to the House Health and Government Operations Committee
Behavioral Health System of Care Update Report

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Maryland Behavioral Health System of Care Update

Dennis R. Schrader, Chief Operating Officer
Lisa A. Burgess, M.D., (Act.) Dep. Secretary, Behavioral Health Administration

December 10, 2019

Behavioral Health System of Care Goals

- System of Care Workgroup on how Maryland should provide, administer, and finance Medicaid behavioral health services with the Total Cost of Care model.
- Goal: increase care coordination and quality for Medicaid enrollees, be cost efficient, and promote access to care.
- Align: with the Governor's Commission to Study Mental and Behavioral Health and the behavioral health cost-based rate setting (HOPE Act of 2017).

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Commission to Study Mental and Behavioral Health

- Co-Chairing Finance Subcommittee
  - 6 meetings to date
  - Initial recommendations to be included in the Commission's December report
- Providing staff and analytic support to the Crisis Services Subcommittee

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HOPE Act (2017) Rate Study

- Requires an independent, cost-driven, rate-setting study to set community provider rates for community-based behavioral health services
- Department has held 5 meetings with behavioral health providers and determined that:
  - A great deal of work needs to be done on provider readiness; anticipated to be a one-year process
  - Concurrently, a request for proposals will be issued; also anticipated to be a one-year process

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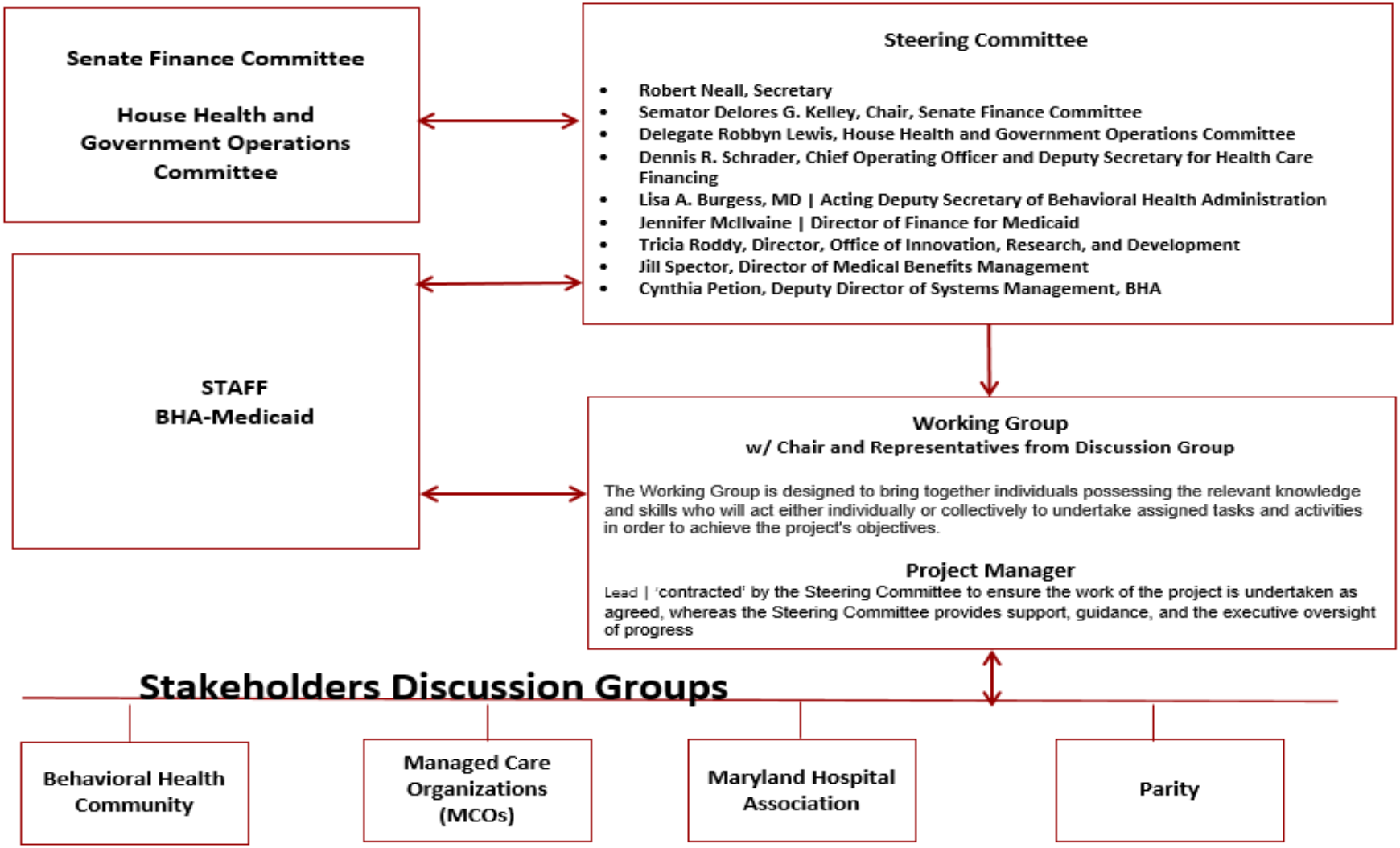
System of Care Design Team



System of Care Progress

- System of Care Design Principles (Fall 2019) around:
  - Quality Integrated Care Management
  - Oversight and Accountability
  - Cost Management
  - Access to Behavioral Health Services through Provider Administration and Network Adequacy
  - Parity
- Now working on:
  - Operational framework to implement the principles
  - Documenting the system processes and improvements needed

Next Steps

- Winter 2019, early Spring 2020:
  - Finalize Framework to Propose, Organize, and Discuss Categories of Improvements and Specific Ideas to Operationalize the Design Principles
  - Refine and seek operational improvements to system processes
- Summer/Fall 2020:
  - Discuss and begin to implement initial system changes based on findings from Principles and Framework

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Behavioral Health System of Care: Progress Update

December 9, 2019

Behavioral Health System of Care: Progress Update

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Behavioral Health System of Care: Progress Update

I. Introduction

Two bills were introduced during the 2019 legislative session that sought to change the delivery and financing of Medicaid behavioral health services in Maryland. As a result of the corresponding discussions, the Chairs of the Senate Finance and Health and Government Operations Committees requested the Maryland Department of Health (the Department) to convene a System of Care Workgroup to examine and make recommendations on how the state should provide, administer, and finance Medicaid behavioral health services in conjunction with the Total Cost of Care Model. These recommendations should increase care coordination and quality for Medicaid enrollees, be cost efficient, and promote access to care.

This report serves as a briefing to the Committees on the Department's System of Care efforts. The Department has made significant progress over the summer and fall of 2019 to engage a broad array of stakeholders in the development of System of Care design principles and to begin developing a framework for operationalizing these design principles. The Department will continue to work with stakeholders on this framework in 2020 and intends to discuss recommendations and further updates prior to the 2021 legislative session.

II. Work Plan and Design Team

As a first step, the Department developed a work plan to ensure that the System of Care activities are in alignment with two other overarching behavioral health initiatives in the State: the Governor's Commission to Study Mental and Behavioral Health in Maryland[1] and behavioral health rate setting as required by the HOPE Act of 2017[2] (See Appendix A for the full work plan). The Department then assembled a design team to implement this work plan (See Appendix B). The design team has five core components:

- The Senate Finance and House Health and Government Operations Committees.
- A Steering Committee that includes Senator Kelley, Delegate Lewis, Secretary Neall, and Department senior leadership. The Steering Committee initially met in September 2019 and expects to continue to meet bimonthly.
- A dedicated Medicaid and Behavioral Health Administration (BHA) staff support team that has been meeting at least biweekly since July 2019.
- The System of Care Workgroup, which undertakes assigned tasks and activities to achieve the project's objectives. The Workgroup has been meeting monthly since July 2019.
- A set of four stakeholder discussion groups that inform Workgroup deliberations: Behavioral Health Community, Managed Care Organizations (MCOs), Parity, and the

[1] See https://governor.maryland.gov/ltgovernor/commission-to-study-mental-and-behavioral-health-in-maryland/
[2] See the Heroin and Opioid Prevention Effort and Treatment Act of 2017, available here: http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_571_hb1329E.pdf.

Maryland Hospital Association (MHA). The Behavioral Health Community and MCO discussion groups have each met monthly since July 2019. The Parity discussion group held its initial meeting in October 2019 and expects to meet again in December 2019 and periodically thereafter. Department staff met with MHA in October 2019 and will continue to meet with them periodically.

III. Workgroup Membership and Progress

The Department established a multi-stakeholder Behavioral Health System of Care Workgroup in July 2019. Membership includes representation from mental health consumer groups, substance use disorder consumer groups, behavioral health providers, local systems managers, hospitals, MCOs, and local health departments (See Appendix C for the full membership list).

The Workgroup has focused on developing a set of design principles with the following goal:

> To better serve Medicaid participants, develop a system that addresses alignment of Medicaid/the Behavioral Health Administration, the MCOs, the administrative service organization (ASO), and the local systems managers.

The design principles are organized around five key components (See Appendix D for the current list of principles):

- Quality Integrated Care Management
- Oversight and Accountability
- Cost Management
- Access to Behavioral Health Services through Provider Administration and Network Adequacy
- Parity

The Workgroup is now working on developing a framework to propose, organize, and discuss categories of improvements and specific ideas to operationalize the design principles (See Appendix E for the draft framework). Workgroup meeting materials and summary notes may be found at https://mmcp.health.maryland.gov/Pages/BH-System-of-Care.aspx. See Appendix F for the Workgroup meeting calendar.

Concurrent with the Workgroup, Department staff are also making progress on documenting various system processes. See Appendix G for a flowchart that outlines behavioral health payment and systems management flows.

IV. Governor's Commission to Study Mental and Behavioral Health

Governor Hogan signed an Executive Order on January 10, 2019 to create the Commission to Study Mental and Behavioral Health in Maryland.[3] The Commission is tasked with studying

[3] https://governor.maryland.gov/ltgovernor/commission-to-study-mental-and-behavioral-health-in-maryland/

behavioral health issues in Maryland, including access to services and the link between mental health and substance use disorders. The Commission issued an interim report in July 2019; another report is expected in December 2019. Dennis Schrader, the Department's Chief Operating Officer and Medicaid Director, is co-chairing the Finance Subcommittee of the Commission. This Subcommittee has held six meetings to date, and initial recommendations will be included in the Commission's December report. Subcommittee perspectives have been incorporated into the System of Care processes described above. The Department is also providing staff and analytic support to the Commission's Crisis Services Subcommittee.

V. HOPE Act Rate-Setting Study

The Heroin and Opioid Prevention Effort and Treatment Act of 2017 (HOPE Act) requires the Department to conduct an independent, cost-driven, rate-setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community-based behavioral health services.[4] To implement this requirement, the Department held five meetings with the behavioral health provider community over the summer and fall of 2019 and determined that at least a one-year readiness effort is required to engage and train providers to provide the data necessary to conduct the study. Concurrently, the Department is developing a request for proposals for a consultant to conduct the study; this is also anticipated to be a one-year effort.

4 http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_571_hb1329E.pdf

Appendix A. Behavioral Health System of Care Work Plan, May 9, 2019

HB846/SB482 from the 2019 Session of the General Assembly, *Maryland Medical Assistance Program – Managed Care Organizations – Behavioral Health Services*, proposed to carve behavioral health services into the HealthChoice Program. These bills were the beginning of an important conversation to bring stakeholders together to try to improve the way behavioral health services are coordinated with somatic services in HealthChoice. During the debate, the Department of Health offered a Letter of Information that provided the broad outlines of a System of Care that could hopefully advance the discussion.

The Chairs of the Senate Finance and Health and Government Operations Committees requested that the Department convene and lead an interim workgroup to examine and make recommendations on how the State should provide, administer, and finance behavioral health in conjunction with the Total Cost of Care Model that increases the coordination and quality of somatic and behavioral health care for Medicaid enrollees, is cost efficient, and promotes access to care. The Committees request a briefing of this work prior to the 2020 Session.

We propose to do this work during the summer and fall of this year (2019). The attached chart begins to outline a structure for managing this project. The structure of the project should be framed around the following three initiatives:

1. Behavioral Health System of Care Design
2. Behavioral Health Rate Setting (required by 2017 Hope Act)
3. Maryland Behavioral Health (MBH) Commission

I. System of Care Design

A well-functioning behavioral health system should include three design components:

- Quality Integrated Care Management
- Cost Management
- Behavioral Health Provider Management and Network Adequacy

These three components should have the following criteria:

- Quality Integrated Care Management
    - Ensure that our State's health care providers, both behavioral health and somatic providers in coordination with the managed care organizations (MCOs), are delivering quality health care that addresses coordinating somatic and behavioral health needs.
    - Ensure that the system of care comports with mental health parity requirements.
- Cost management
    - Ensure that the system has appropriate measures and tools in place to be effective from a cost management perspective.
- Behavioral Health Provider Management and Network Adequacy
    - Ensure that Marylanders have access to quality health care providers.

- Minimize the administrative burden on behavioral health providers as they achieve accreditation compliance, adapt to fee-for-service model, and raise the level of industry quality.
- Avoid the overhead of dealing with multiple and different administrative systems.

One could argue that the current state has elements of the third design component, but not the first two.

Next Steps: Convene a stakeholder group to discuss the System of Care Design over the summer with representatives from the provider, advocate, consumer, and legislative communities.

II. Behavioral Health Rate Setting

In accordance with SB 280 -Labor and Employment – Payment of Wages – Minimum Wage, the Department is required to increase behavioral health provider rates between 3 and 4 percent annually until 2026. In addition, the 2017 HOPE Act requires the Department to conduct an independent, cost-driven, rate setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community-based behavioral health services. This work should be complete by December 2019.

Given the mandatory rate increases and the amount of work required to conduct the cost studies, the Department will ask the Legislature for more time to complete the cost studies. The work will need to be done by a contractor through the State's procurement system. We expect the contractor to be an expert in financial auditing and to provide technical assistance to providers to ensure that the cost reports are completed accurately.

Next Steps: Develop a Request for Information and procure a contractor.

III. Commission to Study Mental and Behavioral Health in Maryland

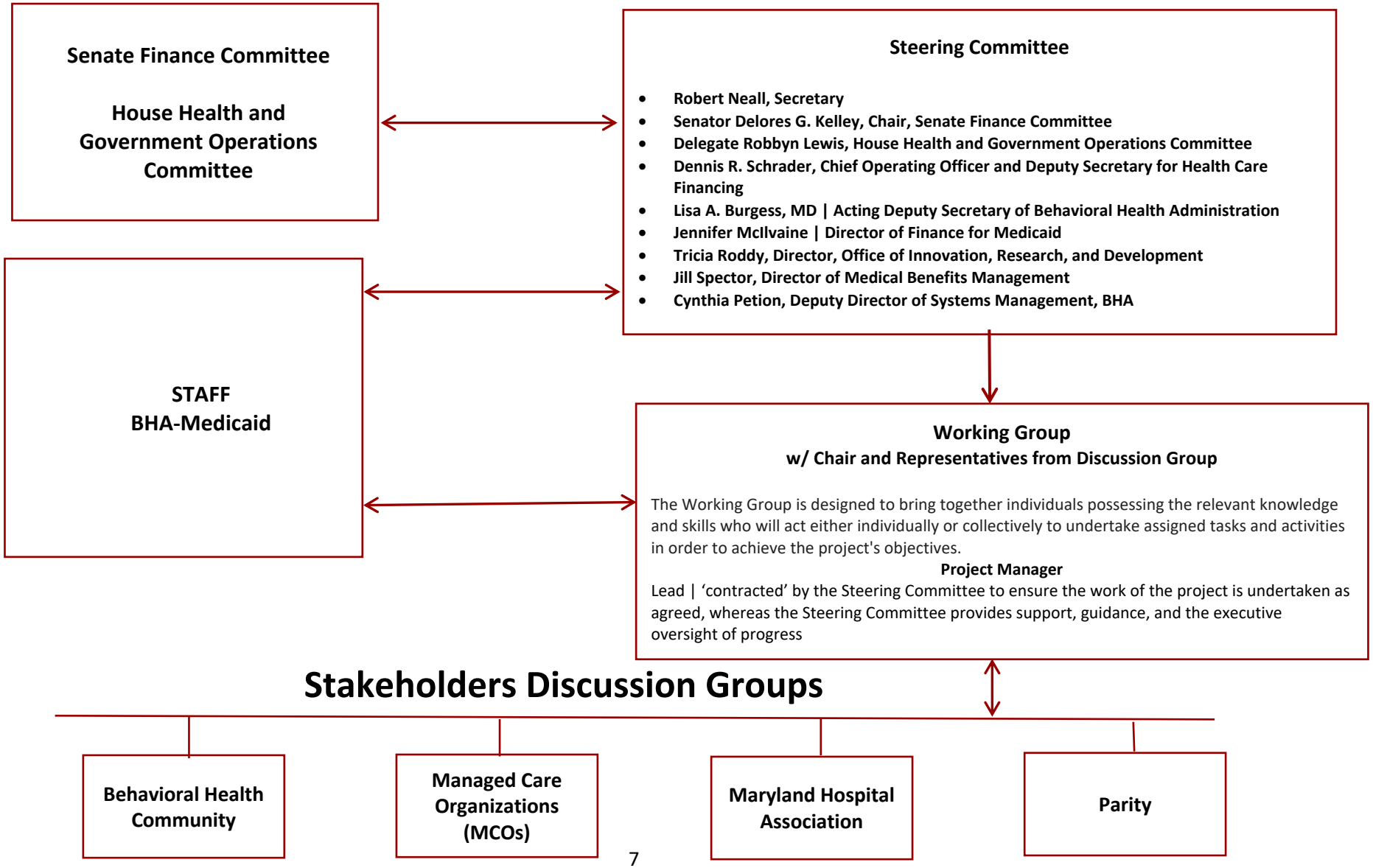
An Executive Order was signed by Governor Hogan on January 10, 2019 to create the Commission to Study Mental and Behavioral Health in Maryland. The Commission was created to provide a forum for the State to continue to ensure a coordinated, high quality system of care by coordination among state agencies, local governments and community partners to establish best practices and improve the State's Public Mental Health System.

The Commission's membership includes members of the Executive, Legislative, and Judicial branches of government, as well as public members who live in Maryland. The Commission is responsible for advising and assisting the Governor in improving access to a continuum of mental health services across the State, review findings of reports, conduct regional summits across the State and submit an interim report by June 2019 and a final report by December 31, 2019. The final report must include, but is not limited to, recommendations for policy, regulations or legislation to improve the statewide, comprehensive crisis response system and ensure parity of resources to meet mental health needs.

The Commission will review access to mental health treatment services, improving statewide, comprehensive response system and ensure parity of resources to meet mental health needs. There will be four subcommittees to work through these issues: Financing and Funding, Youth and Families, Crisis Services, and Criminal Justice.

Next Steps: The work of the Commission will assist the overall work to develop an appropriate System of Care.

Appendix B. Behavioral Health System of Care Design Team



Appendix C. System of Care Workgroup Membership

Co-Chairs

- Dennis Schrader, Medicaid Director and Chief Operating Officer of the Maryland Department of Health
- Dr. Lisa Burgess, Acting Deputy Secretary of the Behavioral Health Administration and Medicaid Chief Medical Officer

Members

Organization	Stakeholder Represented	Name
Mental Health Association of Maryland	Mental Health Consumer Groups	Linda Raines
Community Behavioral Health Association	Providers	Lori Doyle
National Council on Alcoholism and Drug Dependence - Maryland	Substance Use Disorder Consumer Groups	Ann Ciekot
Maryland Association of Behavioral Health Authorities	Local Systems Manager	Crista Taylor
Maryland Association for the Treatment of Opioid Dependence	Provider	Vickie Walters
MedStar Health System	Hospitals	Eric Wagner
Sheppard Pratt	Hospitals	Harsh Trivedi
Bon Secours/New Hope	Providers	Jocelyn Bratton Payne
Amerigroup	MCOs	Laura Herrera Scott
United Healthcare	MCOs	Arethusa Kirk
REACH	Providers	Yngvild Olsen
Black Mental Health Alliance	Mental Health	Jan Desper-Peters
Baltimore County Health and Human Services	LHD	Gregory Branch

Appendix D. Behavioral Health System of Care Design Component Quality Principles

Preamble

Goal: To better serve Medicaid participants, develop a system that addresses alignment of Medicaid/the Behavioral Health Administration, the managed care organizations (MCOs), the administrative service organization (ASO), and the local systems managers.

Quality Integrated Care Management

Person-/Community-Centered/Family-Focused

- The system should engage participants in the treatment and recovery process**.**
- The system should be simple and flexible enough for participants and families to understand and navigate.

Quality/Effectiveness of Care

- The system should be designed with a chronic disease management foundation coupled with early detection and intervention. It further uses a recovery model that includes stages of change and levels of care where complexity is the rule, not the exception.
- Quantitative and qualitative person-centered outcome measurement should determine if people are getting better. Use evidence-based treatment and promising practices where evidence exists.
- The system should have strong case management, person-centered treatment planning, data collection, and transition planning processes that align ASO, MCO, provider, and local system management efforts.
- The system should integrate physical and behavioral health provider plans of care. Follow up should include outreach, case review, and regular communications with local systems managers.
- Within behavioral health, mental health and substance use disorder treatment should be integrated.
- The system should assure seamless integration with non-Medicaid behavioral health services for Medicaid participants.

Data Sharing and Clinical Outcomes/Process Measurement

- Data flows between the ASO and MCOs should be optimized to improve care coordination and participant information sharing, while maintaining legally required participant confidentiality standards, including current 42 CFR Part 2 regulations, as well as the new proposed Part 2 regulations under federal review.

- All providers should have access to read-only, real-time, easily interpretable, and actionable ASO data, and behavioral health providers should have the ability to feed electronic health record (EHR) data into the system.

Oversight and Accountability

- To the greatest extent possible, individuals should not experience disruption in their clinical treatment as their payer status changes.
- Ensure that there is accountability for providing participants with navigation assistance as they move through the continuum of coverage, which includes transitions in and out of Medicaid, Medicare (both duals and those turning 65), and uninsured spans.
- The system should have clearly-defined responsibilities across the various regulatory and accrediting authorities.
- System design should facilitate cross-agency coordination, including state agencies, the ASO, MCOs, and local systems managers, to ensure that timely care coordination occurs as individuals move across systems.

Cost Management

- The system should have shared deliverables for health outcomes from the ASO, MCOs, and local systems managers, and all parties should be held accountable for their performance.
- The system should lower costs in the Total Cost of Care Model through reduction of waste and inefficiency, improved treatment effectiveness, better coordination of physical and behavioral health, and adequate availability of community alternatives to hospitalizations.
- The system should manage high utilizers within a chronic disease management framework.
- The system should provide shared financial and other incentives to promote positive clinical outcomes.
- System design and contract terms should incentivize communication among providers and payers to ensure optimal use of funds.
- The system should prevent cost-shifting to other state agencies.

Access to Behavioral Health Services through Provider Administration and Network Adequacy

- The system should minimize duplicative overhead burden for providers.
- Authorization decisions must be timely.
- Providers in the system should be measured by clinical outcomes.

- The system should account for the right mix of providers to include provider types and geographic distribution.
- The system must work for both programs (facilities) and independently practicing clinicians.
- The system must provide for fair, impartial, and timely internal and external grievance and appeals processes.
- People should be treated in the most appropriate and least restrictive environment possible.
- Behavioral health resources management should be comparable to somatic management practices and implemented through strong qualified provider standards that are supported by efficient oversight and compliance mechanisms or a rating system.

Parity

- Maryland's public behavioral health system must comply with federal and state parity laws, and oversight measures must be implemented to track compliance.
- Treatment of behavioral health should have equal priority with physical health care.

Definitions of Key Terms

Care Coordination - Care coordination involves optimally organizing participant care and information-sharing activities. This means that the participant's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the participant (Agency for Healthcare Research and Quality, https://www.ahrq.gov/topics/care-coordination.html).

Case Management - Assessing, planning, coordinating, monitoring, and arranging the delivery of medically necessary, health-related services (COMAR 10.09.62.01(B)(23)).

Case Management Lifecycle – Refers to case management across a participant's lifespan.

Chronic Disease - A condition or conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both and for which there is no cure. (https://www.cdc.gov/chronicdisease/about/index.htm).

Chronic Disease Management Model - An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and participant education. It can improve participant quality of life while reducing health care costs by preventing or minimizing the effects of a disease (https://www.healthcare.gov/glossary/chronic-disease-management/).

Clinical Outcome Measures – Measures that reflect the impact of the health care service or intervention on the health status of participants (Agency for Healthcare Research and Quality https://www.ahrq.gov/talkingquality/measures/types.html).

Community-Centered - Addressing individual health needs while systematically addressing community conditions that affect individual health (https://www.cdc.gov/pcd/issues/2016/16_0262.htm).

Continuum of Care - An integrated system of care that guides and tracks an individual over time through a comprehensive array of health services spanning all levels of intensity of care (NIMH, https://www.ncbi.nlm.nih.gov/pubmed/10293297).

Culturally and Linguistically Appropriate - Effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs (HHS Office of Minority Health, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53).

Discharge Planning - A process that involves determining the appropriate post-hospital discharge destination for a participant; identifying what the participant requires for a smooth and safe transition from the hospital to his/her discharge destination; and beginning the process of meeting the participant's identified post-discharge needs (Centers for Medicare and Medicaid Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf).

Early Detection and Intervention- Addresses a behavioral health condition early in its manifestation, is relatively low intensity, is of relatively short duration, has the goal of supporting wellbeing in major life domains and avoiding the need for more extensive behavioral health services, and may include individual screening for confirmation of potential behavioral health needs (https://www.rcdmh.org/MHSA/pei).

Evidence-Based Treatment - Refers to a set of standardized, replicable interventions for which rigorous scientific research exists to demonstrate the effectiveness of the interventions, when implemented as designed, in achieving meaningful, positive outcomes for individuals who have received the interventions. Fidelity Assessments and evaluations are systematically performed to determine adherence to established Evidence Based Practice standards (Mona Figeroa, BHA Director of Evidence Based Practices).

Family-Focused - Recognizes the important role of family members and caregivers in the design and implementation of services (SAMHSA, https://www.samhsa.gov/section-223/care-coordination/person-family-centered).

High Utilizers - Also known as high cost users. A group of persons who account for a disproportionately large share of all medical charges (NIH, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192887/).

Integration - The care that results from a practice team of primary care and behavioral health clinicians, working together with participants and families, using a systematic and cost-effective approach to provide person-centered care for a defined population (Peek CJ and the National Integration Academy Council. Lexicon for behavioral health and primary care integration:

concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/lexicon).

Least Restrictive Environment Possible - Treatment and services which will best meet the participant's treatment and security needs and which least limit the participant's freedom of choice and mobility (https://www.dhs.wisconsin.gov/clientrights/cgdd-least-restrictive.pdf).

Local Systems Manager - The Core Service Agencies (CSAs), Local Addictions Authorities (LAAs), and Local Behavioral Health Authorities (LBHA) who are responsible for planning, developing, and managing a full range of treatment and rehabilitation services for persons with serious mental illness and substance use disorder in their jurisdictions. These agencies collaborate with other human service agencies to promote comprehensive services for individuals with mental illness and substance use disorder who have multiple human needs (Maryland Association of Behavioral Health Authorities, https://www.marylandbehavioralhealth.org/).

Parity – Refers to the implementation of the Mental Health Parity and Addiction Equity Act that requires the provision of mental health and substance use disorder treatment and services at the same level as medical and surgical care. Financial requirements and quantitative treatment limitations for mental health and substance use disorder treatment may be no more restrictive than the predominant requirements for substantially all medical/surgical benefits Non-quantitative treatment limitations must be comparable to and applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits (45 CFR§146.136;(c)). Federal regulations apply parity requirements to Medicaid MCOs and the Medicaid expansion population. All Medicaid beneficiaries who receive services through an MCO must be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the MCO or another service delivery. States must include contract provisions requiring compliance with parity standards in all applicable contracts with Medicaid MCOs and, in states in which mental health and substance use disorder services are delivered through an entity other than an MCO, the state is responsible for evaluating parity compliance and submitting compliance reports to the Centers for Medicare and Medicaid Services and posting reports for the public. (Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008, 81 Fed. Reg. No. 61, 18,390 (March 30, 2016) (to be codified at 42 CFR Parts 133 438, 440, 456, and 457). Available at https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf.)

Person-Centered - Individuals have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual (SAMHSA, https://www.samhsa.gov/section-223/care-coordination/person-family-centered).

Person First Language - Eliminates generalizations, assumptions and stereotypes by focusing on the person rather than their disability. As the term implies, person first language refers to the individual first and their disability second (Texas Council for Developmental Disabilities, https://tcdd.texas.gov/resources/people-first-language/).

Physical Health – Within the context of parity, refers to medical/surgical benefits, which are items or services or medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines). Medical/surgical benefits include long term care services (42 CFR §438.900).

Primary Behavioral Health - Medically necessary primary behavioral health services are provided by primary care providers and are paid for by MCOs (COMAR 10.09.65.14).

Primary Care Setting – Refers to medical care that addresses a participant's general health needs, including the coordination of the participant's health care, with the responsibility for the prevention of disease, promotion and maintenance of health, treatment of illness, maintenance of the participant's health records, and referral for medically necessary specialty care (COMAR 10.67.01.01(B)(140)).

Program - A system of activities performed for the benefit of persons served (CARF, 2019 Behavioral Health Standards Manual).

Promising Practices - Programs and strategies that have some scientific research or data showing positive outcomes in delaying an untoward outcome, but do not have enough evidence to support generalizable conclusions (HHS-NIH, Using What Works).

Provider (Organization or Individual) - means an individual, association, partnership, corporation, unincorporated group, or any other person authorized, licensed, or certified to provide health services (COMAR, 10.09.33.01).

Recovery - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, https://store.samhsa.gov/system/files/pep12-recdef.pdf).

Serious Mental Illness - A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI (NIMH, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml).

Specialty Behavioral Health - Any behavioral health service other than primary behavioral health services (COMAR 10.09.60.01(B)(166)).

Specialty Care Setting – Refers to health care services that are either outside the primary care provider's scope of practice or, in the judgment of the primary care provider, are not services that the primary care provider customarily provides, is specifically trained for, or is experienced in (COMAR 10.67.01.01(B)(167)).

Substance Use Disorder - When the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMHSA, https://www.samhsa.gov/find-

help/disorders)(Diagnostic and Statistical Manual of Mental Disorders (5th ed.), American Psychiatric Association, 2013).

Trauma-Informed - An understanding of trauma and an awareness of the impact it can have across settings, services, and populations as well as recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic (SAMHSA, https://store.samhsa.gov/system/files/sma15-4420.pdf).

Timely - The health care system's ability to provide health care quickly after a need is recognized. A delay in the time between identifying a need for a specific test or treatment and actually receiving those services can negatively impact health and costs of care (https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services).

Total Cost of Care Model - Refers to the 10-year agreement between the State of Maryland and the Centers for Medicare & Medicaid Services governing Maryland's all-payer hospital system. For more information, see https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf.

Uninsured – A person who does not have minimum essential health insurance coverage, which includes government-sponsored coverage, employer-sponsored coverage, coverage through the individual market, or other coverage recognized by the U.S. Department of Health and Human Services and the Internal Revenue Service (26 USC §5000A(f)).

Wellness - Being healthy in many dimensions of our lives. That includes the emotional, physical, occupational, intellectual, financial, social, environmental, and spiritual parts. These dimensions are interconnected, one dimension building on another (SAMHSA, https://store.samhsa.gov/system/files/sma16-4958.pdf).

Appendix E. Draft Framework to Propose, Organize, and Discuss Categories of Improvements and Specific Ideas to Operationalize the Design Principles

Improvement Categories:

- Case Management Improvements
- Data Sharing Improvements
- Cost Management Improvements
- Behavioral Health Provider Network Improvements
- Accountability Improvements
- Quality Improvements

Case Management Improvements

- MCO Extended Case Management
- Local Systems Management Standardization
- Regional On-Call Staff
- ASO Case Management Expansion
- Overdose Transitions to Treatment Independent of Participant's Action
- Clear, Timely Pathways to Outpatient and Ambulatory Services
- Improve the Capacity of the Medicaid Managed Care System to Integrate with Non-Medicaid State Systems, Populations, and Services

Data Sharing Improvements

- CRISP - Point of Care
    - Ability to Search by Medicaid Identification Number
- Real-Time, Read-Only Access to ASO Data
- Electronic Access to Provider Directories, Particularly for Medication Adherence: Provider Letters
- Prescription Data Visibility
- Use Cases for Data Sharing: Immediate Access to Diagnosis and Treatment Information for Case Management and Access to Claims/Prescription Information for Data Mining
    - Provide Prescription and Claims Files in a Traditional Format, e.g., 837
    - Provide Recent Participant Contact Information
- Pharmacy Benefit Manager (PBM) Data Cycles
- Make Better Use of Health Information Systems to Improve Data Sharing

Cost Management Improvements

- Capitated ASO
- Managed Behavioral Health Organization (MBHO)
- High Utilizers: Chronic Disease
    - Opioid Use Disorders
    - Diabetes
- Contracts between ASO, MCOs, and Local Systems Managers

Behavioral Health Provider Network Improvements

- Define Network Adequacy
    - Increase Management of the Behavioral Health Provider Network and Ensure Appropriate Enforcement of Current Regulations
- Improve Referral Processes
- Define Local Systems Manager Roles
    - Integrate and Better Define Roles and Responsibilities for Local System Management Agencies
- Obtain Better Understanding of Provider Types and Scopes of Work

Accountability Improvements

- Performance-Based Metrics
    - Implement Uniform and System-wide Measurement-based Care Standards for Mental Health and Substance Use Disorders
- Score Cards
- Standards of Practice
- Define Who is Accountable

Quality Improvements

- Medication Adherence, e.g., MAT
- Shared Quality Activities, e.g., HEDIS Measures
- Improve the Quality and Cost Predictability of Care by Expanding Value-Based Payments in Behavioral Health. Ensure Care is Patient-Centered by Increasing Provider Flexibility and Expanding Value-Based, Outcome-Focused Service Delivery Across Systems

Appendix F. Behavioral Health System of Care Workgroup Meeting Schedule

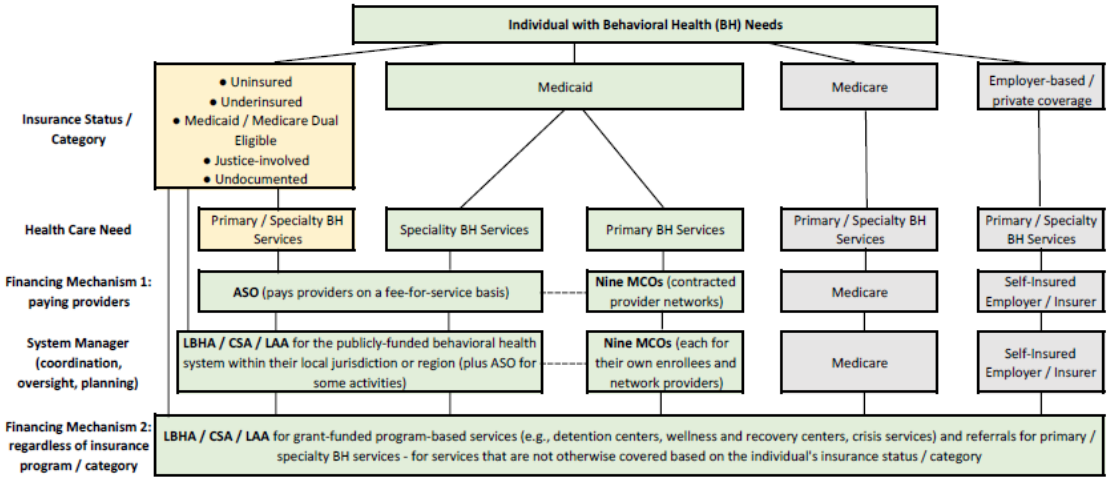
Location:
Maryland Department of Health
201 W. Preston Street
Baltimore, MD 21201

- Meeting 1
  - Date: Wednesday, July 31
  - Time: 9:00 a.m. to 12:00 noon
  - Meeting Room: L3
- Meeting 2
  - Date: Thursday, August 22
  - Time: 9:00 a.m. to 12:00 noon
  - Meeting Room: L1
- Meeting 3
  - Date: Thursday, September 26
  - Time: 9:00 a.m. to 12:00 noon
  - Meeting Room: UMBC Tech Center South Campus, Seminar Room, 1450 South Rolling Rd, Baltimore, MD 21227
- Meeting 4
  - Date: Wednesday, October 23
  - Time: 9:00 a.m. to 12:00 noon
  - Meeting Room: Behavioral Health Administration | Spring Grove Hospital Ctr., 55 Wade Avenue, Catonsville, MD 21228, Dix Building, Basement Conference Room
- Meeting 5
  - Date: Thursday, November, 21
  - Time: 9:00 a.m. to 11:00 a.m.
  - Meeting Room: L3
- Meeting 6
  - Date: Monday, December 16
  - Time: 3:00 p.m. to 5:00 p.m.
  - Meeting Room: Behavioral Health Administration | Spring Grove Hospital Ctr., 55 Wade Avenue, Catonsville, MD 21228, Dix Building, Basement Conference Room

Appendix G. Current State: Payment and Systems Management Flow

CURRENT STATE: PAYMENT AND SYSTEMS MANAGEMENT FLOW

DRAFT as of 11.05.19



NOTES:

*1. This flow-chart is **intentionally high level** to show core roles and relationships -- it does **not** reflect every possible detail and relationship.*

2. The Maryland behavioral health system sometimes pays for and/or manages services and treatment for: a) people who are residents of other states; and, b) Maryland residents who are receiving behavioral health care or treatment in other states.

3. System Manager functions also involve coordination with other safety net systems such as housing, hospital emergency departments, schools, jails, etc.

ACRONYMS AND BASIC DEFINITIONS:

ASO = Administrative Services Organization under contract with Medicaid to serve all of Maryland
BH = behavioral health
CSA = Core Service Agency (local authority for mental health, authorized by the Maryland Behavioral Health Administration))
LAA = Local Addictions Authority (local authority for substance use and addiction, authorized by the Maryland Behavioral Health Administration)
LBHA = Local Behavioral Health Authority (local authority for behavioral health [merged CSA & LAA], authorized by the Maryland Behavioral Health Administration)
MCO = Managed Care Organization under contract with Medicaid; four serve all of Maryland and five only serve specific local jurisdictions
Primary BH Services = BH services provided in a primary care setting
Specialty BH Services = BH services that are not provided in a primary care setting
Underinsured = Includes anyone whose insurance does not cover the specific BH services they need (e.g., Medicare, some employer-based / private coverage)