MARYLAND
Department of Health

Notes
Behavioral Health System of Care Workgroup Meeting
August 22, 2019

Maryland Department of Health, L1 Conference Room
201 W. Preston Street
Baltimore, MD 21201

Members In Attendance

Dennis Schrader, Co-Chair
Lisa Burgess, Co-Chair
Linda Raines
Lori Doyle
Nancy Rosen-Cohen for Ann Ciekot
Crista Taylor
Vickie Walters

Eric Wagner
Harsh Trivedi
Laura Herrera Scott
Jan Desper-Peters (by phone)
Gregory Branch
Arethusa Kirk

Members Absent

Jocelyn Bratton-Payne
Yngvild Olsen

Introduction

The Co-Chairs welcomed members and thanked Dr. Kirk for joining the workgroup. After the workgroup members and staff introduced themselves, Mr. Schrader noted that the meeting is public and being recorded.

Workgroup Overview

The Co-Chairs reminded members of the workgroup's purpose: to synthesize principles and build consensus around design components for a system of care. They discussed the group's meeting schedule and updates to the design team, including the addition of Senator Delores Kelley and Delegate Robbyn Lewis to the Steering Committee. The Steering Committee is expected to meet in mid-September. The workgroup will continue to refine the principles through September and will then start discussing design options.

Discussion: Principles and Values

Mr. Schrader and Dr. Burgess led a discussion on the guiding principles for the three system of care design components: quality, integrated care management; cost management; and behavioral health provider management and network adequacy. The purpose of the discussion was to validate and expand upon the topics discussed at the previous meeting. The workgroup aims to reach consensus around four to six statements for each of three design components.

The group proceeded to discuss the list of principles. Please note that the following statements do not necessarily reflect workgroup consensus, but a catalogue of topics discussed.

The workgroup began with the quality integrated care management category.

- The system should optimize the chance of success in the treatment process.

- The system must recognize the strong relationship between physical and behavioral health.

- The system's commitment to equity should explicitly include the transgender population and age.

- The principle of involving clients in the goals, plans, and design of the system should be expanded to include clients' families.

- The system should place focus on the quality and effectiveness of care and allow providers the flexibility to offer innovative treatments.

- A focus on medication adherence is too narrow and should be expanded to treatment engagement more broadly.

- The system should ensure timely treatment and reduce the delay to the first appointment with a provider.

- The system should provide clear avenues of feedback to oversight authority. At the same time, duplicative oversight authority should be eliminated.

- The system must recognize the critical function of local organizations. Oversight and accountability at the local level should be a central focus, with the goal of aligning efforts between the local and State systems.

- Any effort to support improvements in the system's technology should include both data sharing and treatment delivery.

- Data sharing under the current system contains blind spots and otherwise limited visibility for the managed care organizations (MCOs). The system should allow for at least read-only access to administrative service organization (ASO) files.

- Current telehealth regulations hamper data sharing and care coordination.

- The system should create a state-of-the-art process to measure outcomes in order to answer the question as to whether people seeking and getting care are getting better. Such a process should be consistent across all of HealthChoice—ideally, across all payers.

- The system should encompass both trauma-informed and strength-based care.

- The system should maintain its current strength in continuing care when the client's payer changes. This includes transitions in and out of Medicaid, but also in and out of age groups, such as childhood to adolescence or adolescence to adulthood, especially those aging out of foster care.

- The system should carefully evaluate how to approach social determinants of health since they are highly important to health outcomes, but not a major focus of the current system. The system can realize savings on treatments that could be rendered unnecessary by improvements in social determinants, including stable, affordable housing.

- The system must recognize the importance of parity between behavioral and physical health. The system should go beyond compliance with the letter of the law by prioritizing physical and behavioral health equally.

- The system should integrate mental health and substance use disorder treatment.

- The system should require, rather than just encourage, evidence-based treatment.

- There should be a stand-alone category for principles regarding quality of care.

Next, the workgroup discussed the design principles around cost management.

- The system should focus on underlying behavioral health concerns that drive high utilizers into the emergency department (ED) as their primary locus of care. Medicaid members with a behavioral health diagnosis use hospital services at a much higher rate than the general Medicaid population.

- The system should make it easier for clients to be placed in community-based care.

- The current system has gaps in case management and discharge planning for the behavioral health population. Concern was expressed about consumers "falling through the cracks."

- Concern was expressed that the current ASO does not have an incentive to manage members.

The workgroup then moved on to provider management and network adequacy.

- The system should minimize the burden on providers contracting with all nine Medicaid MCOs.

- The system should not require providers to undergo more change than they can reasonably absorb at once.

Discussion: Current System Flow Chart

Mr. Schrader explained that, in order to design a system, the current system needs to be diagrammed in a flow chart. The Co-Chairs invited workgroup members to share their thoughts on a preliminary draft flow chart intended to demonstrate how client data flows through the current system. The workgroup discussed the following:

- Members requested data on the number of public behavioral health system participants by jurisdiction and service category. They also requested data on service availability and volume.

- The chart should include information on individuals with co-occurring disorders.

- The chart should show how client information is distributed among local behavioral health authorities.

Public Comment

The Co-Chairs opened the floor to members of the public.

Ellen M. Weber, J.D., Vice President for Health Initiatives at the Legal Action Center, thanked the workgroup for focusing on parity, noting that each principle discussed is implicated in the Mental Health Parity Act. In order to achieve the goals of this process, she noted that the State must comply with the Parity Act correctly. She added that, prior to the substance use disorder carve out, care coordination was a reimbursed service in the system. She concluded by stating that data collection on parity requirements is critical and should be built into the ASO contract.

Steve Daviss, MD, DFAPA, President of Fuse Health Strategies, LLC, introduced himself as a psychiatrist and member of the Finance and Funding Subcommittee of the Governor's Commission to Study Mental and Behavioral Health. He noted that greater investment in behavioral health often results in savings in physical health. Dr. Daviss encouraged the workgroup to think about how to distribute those savings. He added that the workgroup should create a client data flowchart for a somatic patient and see how it compares with the behavioral health flowchart.

Meeting Close

The Co-Chairs thanked workgroup members for their participation.