MARYLAND
Department of Health

Notes
Behavioral Health System of Care Workgroup Meeting
November 21, 2019

Maryland Department of Health, L3 Conference Room
201 W. Preston Street
Baltimore, MD 21201

Members In Attendance

Dennis Schrader, Co-Chair
Lisa Burgess, Co-Chair
Linda Raines (by phone)
Lori Doyle
Ann Ciekot
Crista Taylor
Howard Ashkin for Vickie Walters
Eric Wagner
Jeff Richardson for Harsh Trivedi
Katherine Loughran for Laura Herrera Scott (by phone)
Gregory Branch
Yngvild Olsen
Arethusa Kirk
James Derouselle

Introduction

The Co-Chairs welcomed members. Dr. Burgess announced that the December 16 Workgroup meeting will take place at the Behavioral Health Administration (BHA) offices in the Dix building from 3:00 to 5:00 p.m. She noted that the Workgroup will not meet in January or March 2020.

Discussion: Framework for Improvements to Operationalize the Design Principles

Mr. Schrader set the expectation that the Workgroup will now begin to turn the principles into a framework for improvements to the system. To that end, he described six draft categories of improvement identified by staff:

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

- Accountability Improvements
- Quality Improvements

Mr. Schrader added that the managed care organization (MCO) and behavioral health community stakeholder discussion groups had already begun to provide feedback, noting that two additional categories were proposed including recipient experience and treatment experience. Finally, he directed the Workgroup's attention to a document prepared by the Maryland Behavioral Health Coalition. The Workgroup proceeded to discuss each improvement category. Please note that the summaries of Workgroup discussions below do not necessarily reflect consensus, but rather are a catalogue of topics discussed.

Quality Improvements

Mr. Schrader asked Workgroup members to respond to the proposed quality improvements. The ensuing discussion included the following:

- One participant suggested that the document explicitly reference evidence-based care.
- A participant commented that the Healthcare Effectiveness Data and Information Set (HEDIS) is widely used to measure MCO performance on physical health for Medicaid recipients, for instance in the value-based purchasing (VBP) program. HEDIS measures may not be robust enough for behavioral health purposes. Despite that deficiency, the Workgroup should identify HEDIS measures that can serve well for behavioral health.
- The Centers for Medicare & Medicaid Services (CMS) Scorecard is a possible set of measures to which the Maryland system's stakeholders can agree. Maryland Medicaid must undertake efforts to improve data quality in order to report to CMS.
- While a focus on data and data quality may be required in order to comply with federal requirements, a participant commented that the system should work to improve the lives of those in need of care, including supports outside the traditional medical categories such as housing and employment.
- A participant expressed concern that medication adherence programs can be coercive and that the State should avoid coercion by maintaining person-centrality. Strategies to support medication adherence without coercion can include coordination and assistance. A number of technology solutions to support medication adherence without coercion are evolving in the marketplace.
    - A participant commented that peer supports may be a critical part of the improvements in medication adherence.
- A participant expressed concern that case management is reimbursed differentially for substance use services than it is for mental health services.

Accountability Improvements

Mr. Schrader then moved the discussion to improvements around accountability, noting that a first step is to document the current state of the system. He noted that operations manuals for the

administrative service organization (ASO) and local systems managers are in progress. He asked Workgroup members propose specific targeted initiatives around accountability. The Workgroup discussed the following:

- Workgroup members discussed confusion at present about the roles and responsibilities of the local systems managers. Since many—but not all—locals are situated within a local health department (LHD), it is not always clearly understood that locals and LHDs have two different roles.
- The system could leverage the CMS Scorecard to identify measures to which all system participants will be held accountable.

Behavioral Health Provider Network Improvements

Mr. Schrader then asked Workgroup members to provide input on provider networks, especially on the question of what constitutes provider network adequacy in a behavioral health system. Workgroup members discussed the following:

- A participant commented that the system should maintain a focus on improving access to care, especially for those needing treatment for substance use.
- Another participant commented that the system should ensure that the provider networks include only those who provide quality care. On the other hand, the opioid crisis has required an "all-hands-on-deck" approach.
- Workgroup members discussed differences in licensure requirements for clinical professionals and nonmedical providers. While the current system does have licensure requirements for clinical professionals, nonmedical providers including community health workers and peer workers have no licensure.
    - A participant expressed concern that introducing licensure requirements for nonmedical professionals can have the effect of excluding people with strong skills in cultural competency from the system.
- A participant suggested that the system should focus on how to exclude unsuitable providers.
- A participant commented that provider networks and the adequacy thereof should be understood from a patient-centered perspective.

Cost Management Improvements

Next, Mr. Schrader asked the Workgroup to comment on cost management improvements. The Workgroup discussed the following:

- In order to achieve improvements in cost management, a participant commented that the system must reduce emergency department (ED) and inpatient utilization that is not useful for the overall health of the patient. Specific populations of interest in this area include those who have had an overdose, those in the ED for an alcohol-related condition, and those with diabetes who have a complicating behavioral health diagnosis.

- A participant expressed concern that a number of the services necessary to achieve the goals of the system are nonmedical and not reimbursed by Medicaid. Mr. Schrader noted that services that fall outside of Medicaid reimbursement are outside the Workgroup's scope at this time. The Lieutenant Governor's Commission to Study Mental and Behavioral Health in Maryland is looking at crisis services.
- A participant expressed concern that a capitated ASO could introduce perverse incentives, since spending on behavioral health services could result in cost savings on the physical health side.
- A participant noted a model in Pennsylvania where a provider network actively works with MCOs and other payers to manage difficult cases, with savings shared among all. The participant commented that such a system should be developed in Maryland.

Data Sharing Improvements

Mr. Schrader then moved the discussion to improvements in data sharing. He noted recent success in the area of data sharing, including the fact that Medicaid will soon begin sending claims data to the Chesapeake Regional Information System for our Patients (CRISP), the State's health information exchange. Workgroup members discussed the following:

- A participant commented that the State should make a capital investment into the CRISP data system to broaden availability.
- Another participant stated that electronic health record (EHR) systems are not widely adopted in the behavioral health provider community. The system should encourage adoption of interoperable EHR systems.
- A participant expressed concern that significant stigma and discrimination can result from clinical information sharing from behavioral to physical health providers. The system should provide a remedy to those who experience such discrimination.

Case Management Improvements

Finally, Mr. Schrader asked the Workgroup to share their thoughts on improvements to case management. The Workgroup discussed the following:

- A participant suggested that case management communication must include more than just the ASO, MCO, providers, and local systems managers. It must also encompass communications with other agencies, such as criminal justice and housing authorities.
- A participant expressed concern that the involvement of the criminal justice system complicates matters in behavioral health. The system should treat overdose sites as opportunities for public health interventions rather than as crime scenes.
- A participant commented that case management methodologies vary among all system actors. The system should introduce minimum standards for case management.

Other Improvements

Mr. Schrader closed the discussion of system improvements by noting that the stakeholders identified two new categories—parity improvements and system optimization improvements.

Public Comment

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

Steve Daviss, MD, DFAPA, President of Fuse Health Strategies, LLC, stated that the system improvements should encompass a bi-directional integration of primary care with behavioral health.

Meeting Close

The Co-Chairs thanked Workgroup members for their participation.