MARYLAND
Department of Health

Meeting Notes
Behavioral Health System of Care Full Workgroup Meeting
November 20, 2020

Members In Attendance

Aliya Jones, Co-Chair
Tricia Roddy, Acting Co-Chair
Linda Raines
Lori Doyle
Ann Ciekot
Crista Taylor
Vickie Walters
Eric Wagner
Laura Herrera-Scott
Arethusa Kirk

I. Welcome and Updates

Dr. Aliya Jones, Deputy Secretary of the Behavioral Health Administration (BHA), and Tricia Roddy, Assistant Medicaid Director, welcomed everyone and called the meeting to order.

Dr. Jones reported that during the last meeting there were questions about when this Workgroup might return to items they began prior to the COVID-19 pandemic. Dr. Jones stated they have been working to create a list of potential projects and discussion topics to bring to the Workgroup, other than the implementation of the new administrative services organization (ASO) that began earlier this year. Dr. Jones reported that internal conversations have begun regarding gauging stakeholder interest in these items and she hopes they will be presented in an upcoming meeting. Ms. Roddy added that Workgroup members' ideas for projects based on their own interests are welcome.

II. Presentation: Maryland Behavioral Health Solutions

Lori Doyle and Shannon Hall, Public Policy Director and Executive Director, respectively, with the Community Behavioral Health Association of Maryland (CBHAMD), gave a presentation on Maryland Behavioral Health Solutions (MBHS).

Ms. Hall reported that health care costs for individuals with co-occurring behavioral and somatic health conditions are two to three times higher than for those without co-occurring conditions, and that much of this cost burden relates to physical care. Ms. Hall referenced a Milliman report from 2018 that found that integrating somatic and behavioral health care can significantly reduce the costs of care for this population.

Ms. Hall reported that MBHS was launched in 2019 as a for-profit entity separate from CBHAMD, and that providers can participate by becoming a member of CBHAMD, purchasing a stake in MBHS, and becoming a director in the network. Providers can also join MBHS without being a stakeholder or director in the organization, but they must commit to certain reporting and performance standards.

Ms. Hall reported MBHS was created to standardize the reporting of costs, outcomes, and service utilization data; to work with commercial insurers to help them achieve network adequacy goals for behavioral health treatment access; and to pursue value-based purchasing arrangements to achieve these outcomes. Ms. Hall stated MBHS has agreements with providers in 26 behavioral health organizations from every Maryland county except Garrett. Ms. Hall drew particular attention to the number of licensed health homes (44) with MBHS providers, stating the health home model allows for smoother integration of behavioral and somatic care.

Ms. Hall reported that they have mapped their data with the three largest electronic health records companies to standardize data reporting and allow MBHS providers to produce dashboards that help evaluate performance. She continued that many of the participants in the MBHS network have a proven record of partnering with somatic providers to reduce care costs and improve patient outcomes, though these efforts have mostly been via grants or other time-limited demonstrations. Ms. Hall stated that a goal of MBHS is to take these relatively modest successes and scale them up to become the standard across Maryland.

Ms. Doyle reported that the health home model approach includes using predictive technology to identify and intervene early with individuals at risk for crisis or who may require costly levels of care. Nurse care managers in this model coordinate with behavioral health and primary care providers to develop intervention plans, or coordinate transition to the community from emergency treatment. Ms. Doyle reported that the health home approach, when used successfully in the past, relied on trust being established between providers and patients who often did not trust the health care system.

Ms. Hall stated that insurance carriers benefit from MBHS because MBHS has access to providers statewide who have experience with Medicaid enrollees with behavioral health needs. Ms. Hall reported that another benefit is that MBHS aims to make care cost reductions sustainable by also improving members' quality of life.

Dr. Jones asked about the next steps for MBHS. Ms. Doyle responded that MBHS has ongoing discussions with payers, managed care organizations (MCOs), and the Maryland Health Services Cost Review Commission to learn more about their individual needs and if a partnership would be feasible. Ms. Hall reported MBHS spent about two and a half years standardizing provider data reporting, and are now working on standardizing outcome measures. Ms. Hall continued that

they have received positive feedback from providers in the MBHS network who want to continue participating.

Ms. Roddy asked what the nature of an agreement between MBHS and a Medicaid MCO might be. Ms. Doyle responded that it would depend on the needs of the MCO, but they would start by evaluating these needs and asking for data to determine which MBHS provider would be best able to serve the MCO's needs. Ms. Doyle continued that any contract or agreement between MBHS and an MCO would be an ongoing partnership with open and frequent communication.

Arethusa Kirk asked if, in a partnership with an MCO, MBHS would be responsible for identifying MCO members with previously or potentially high health care utilization, or would MBHS find providers for these members. Ms. Doyle responded that MBHS has had discussions with MCOs about whether they should be responsible for identifying members with high utilization, though to what extent this happens will ultimately come down to the specified agreement with the MCO.

Eric Wagner asked if all providers with MBHS are Medicaid providers. Ms. Doyle answered that all MBHS providers are longtime Medicaid providers.

Linda Raines commented that there have been conversations within the Maryland Behavioral Health Coalition, the advocacy arm of the Mental Health Association of Maryland, on how to move forward with value-based purchasing in Maryland, considering the ASO transition and the COVID-19 pandemic. Ms. Raines reported they are preparing to bring two suggestions to MDH:

- To move forward with the Baltimore City Capitation Project,
- To scale up the implementation of collaborative care between behavioral and somatic health care providers within Medicaid.

Ms. Roddy noted that the Department has a collaborative care model pilot underway. Ms. Raines responded that the Maryland Behavioral Health Coalition feels it is important to have ongoing conversations with the Department about these ideas. Ms. Roddy agreed, and added that expansion of the Baltimore City Capitation Project would involve identifying providers across the state who can take on that kind of risk, which not all can.

Dr. Jones asked Ms. Hall and Ms. Doyle if there were particular outcomes MBHS was aiming to improve, and if they have evaluated these outcomes. Ms. Hall responded that the MBHS providers tend to be more willing to innovate, have invested more in innovative technology, and have practice conducting small grant-funded projects using technology to reduce hospital care costs for individuals with co-occurring behavioral and somatic health concerns. Ms. Doyle stated MBHS is evaluating whether and how these innovative techniques can be scaled up to a payer system rather than a single hospital or hospital system. Ms. Doyle responded that the nature of this work means there are numerous possible targeted outcomes of interest, and these could extend to social determinants of health in addition to traditional utilization and cost metrics. Ms. Doyle noted that MBHS would like to have conversations with the state and others about what outcomes are most important to them.

Dr. Jones asked if MBHS has been looking to partner more with commercial payers. Ms. Doyle responded there are opportunities to do so given network adequacy requirements. Ms. Doyle referenced a Lancet article that found that one in five people who recover from COVID-19 will develop behavioral health symptoms of some kind, so there will likely be opportunities for MBHS to partner with commercial payers if demand for behavioral health services increases following the pandemic.

Dr. Jones asked if MBHS has been trying to bring more providers on to consolidate networks. Ms. Hall responded that MBHS is interested in expanding given the impending state budget cuts and rising incidence of behavioral health complaints. She noted that more providers have expressed interest in joining the network, but that data integration remains challenging. Ms. Hall noted that, in six months, MBHS plans to conduct outreach to bring on more providers.

IV. Public Comment

No comments were offered.