MARYLAND
Department of Health

Notes
Behavioral Health System of Care Workgroup Meeting
September 26, 2019

UMBC Tech Center

Members In Attendance

Dennis Schrader, Co-Chair
Lisa Burgess, Co-Chair
Linda Raines
Lori Doyle
Ann Ciekot
Adrienne Breidenstine for Crista Taylor
Vickie Walters
Eric Wagner
Harsh Trivedi (by phone)
Katherine Loughran for Laura Herrera Scott
Jan Desper-Peters (by phone)
Gregory Branch
Jocelyn Bratton-Payne (by phone)
Yngvild Olsen
Arethusa Kirk (by phone)

Introduction

The Co-Chairs welcomed members. They gave the group an update on the recent meeting of the Steering Committee, explaining that Secretary Neall, Senator Kelley, and Delegate Lewis form the core of the Steering Committee. The Co-Chairs noted that they provided the Steering Committee with a briefing on the System of Care effort and described it as an encouraging discussion.

Discussion: Principles

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 access to behavioral health services through provider management and network adequacy. The Workgroup aims to reach consensus around four to six statements for each of three design components.

Mr. Schrader began by describing a new feature of the principles document wherein terms are defined. He explained that many of the design principles themselves became too wordy to serve as a useful filter for policy options. For that reason, staff created a list of terms to be defined such that the additional language need not be included in the principles themselves. Dr. Burgess commented that each participant in the system of care redesign effort may have slightly different definitions of the same terms. For that reason, the Co-Chairs noted that, while staff will create

the definitions, Workgroup members are encouraged to share their understanding of the terms' definitions.

Next, Mr. Schrader explained that feedback from the various System of Care discussion groups has been incorporated into the principles document. He summarized the changes and asked the Workgroup for their input, beginning with the principles under the heading "Quality Integrated Care Management." He noted that this section has been pared down as part of the overall effort to limit the principles document to two pages.

The Workgroup proceeded to discuss the principles in this section. Please note that the following statements do not necessarily reflect Workgroup consensus, but a catalogue of topics discussed.

- The term "providers" should be understood to include more than just behavioral health providers, including hospitals, acute care providers, and primary care providers.
- Members expressed concern about the use of the term "time-limited therapy," noting that while participants may achieve remission and/or recovery, interventions may be required over the life span.
- The term "chronic disease management model" should be clearly defined.
- Members commented on the lack of behavioral health Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- A lack of interoperable electronic health record (EHR) systems has impeded the behavioral health system. The process by which behavioral health providers update information on participants should be simplified as much as possible in order to remove duplicative administrative overhead.
- Data sharing between primary and behavioral health providers should go both ways and be incentivized.
- Providers treating participants with co-occurring mental health, substance use, and/or physical health disorders face challenges in interfacing with the multiple administrative and financial systems.
- Concern was expressed about the current ASO's coding structure, which requires providers to code an encounter as either mental health or substance use disorder, without an option for co-occurring conditions.
- A member suggested a new quality principle: "To the greatest extent possible, participants should not experience disruptions in their clinical treatment or clinical home as their payer status changes." Concern was expressed by several Workgroup members that participants face challenges when they must change medications and providers when their payer status changes.
    - Several other Workgroup members commented that this is not available on the Medicaid physical health side and participants with physical chronic conditions experience similar disruptions when their payer status changes.

Mr. Schrader then moved the discussion onto the areas of "Oversight and Accountability." The Workgroup proceeded to discuss the principles in this section. Please note that the following statements do not necessarily reflect Workgroup consensus, but a catalogue of topics discussed.

- The system should align financial incentives and goals in such a way that physical health and behavioral health providers are accountable for outcomes.
- The system should clarify and simplify the lines of responsibility for all system participants.
- Members requested clarity on the term "fraud and abuse prevention."
- Members requested definitions for the terms "care coordination" and "provider," noting that providers include both individual clinicians and organizations.

Next, Mr. Schrader noted that the principles around parity have not changed, but that a meeting of the Parity Discussion Group is upcoming. He then opened discussion of the principles of "Cost Management." The Workgroup proceeded to discuss the principles in this section. Please note that the following statements do not necessarily reflect Workgroup consensus, but a catalogue of topics discussed.

- Principles of cost management should include consideration of the timeliness of care, given that providers and other system stakeholders are often unable to communicate quickly with the payer for a particular client.
- The system should not be designed in such a way that failure to reduce costs indicates failure of the system. If the need for behavioral health services continues to grow at crisis levels, the system may be able to reduce waste and improve efficiency, yet still cost more in total.
- The system should focus on reducing the total cost of care (TCOC) for individuals and should explicitly state whether the TCOC is only for the duration of the individual's Medicaid enrollment, or for their entire lifespan.

Mr. Schrader concluded the discussion of principles with the section on "Access to Behavioral Health Services through Provider Management and Network Adequacy." He underlined the difference between physical and behavioral health in this area, wherein MCOs have clear standards for their provider networks, while the behavioral health system accepts any willing provider. The Workgroup proceeded to discuss the principles in this section. Please note that the following statements do not necessarily reflect Workgroup consensus, but a catalogue of topics discussed.

- Concern was expressed that differences in network requirements between the physical and behavioral health systems could have parity implications.
- Changes to the "any willing provider" policy will require the system to set standards for network adequacy.
- The system could develop a provider rating system to encourage the use of high quality behavioral health providers while maintaining the "any willing provider" structure.

- Many behavioral health services are delivered by non-physician providers, including residential, supported employment, and crisis services. The system should be designed to respond to outcome measures rather than focusing on clinical competence.

Discussion: Current System Flow Chart

Dr. Burgess presented a newly designed flowchart showing how the behavioral health system manages the care and payment for services of individuals seeking behavioral health treatment. She acknowledged that portions of the flowchart fall outside the Workgroup's area of responsibility, but emphasized the importance of understanding the interaction between Medicaid and other systems. The Workgroup discussed the following:

- Current system flows depend on individuals seeking treatment for behavioral health issues. Members commented on the need for an overall behavioral health wellness/prevention approach.
    - Members discussed how much of the responsibility for prevention and wellness rests in the primary care setting, even though other systems such as housing and education can play an important role.
- Members suggested adding sub-populations to the flow chart.
- Members discussed the important role of the local systems managers and the need for clear guidance on the lines of communication between the locals, the ASO, and the MCOs.
- The chart does not represent the experience of people seeking care who do not qualify for safety net services yet cannot afford treatment.

Public Comment

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

Steve Daviss, MD, DFAPA, President of Fuse Health Strategies, LLC, commended the Workgroup on its efforts. He suggested that the Workgroup should adopt a principle of transparency among all stakeholders around data showing whether or not people seeking treatment are receiving the right kind of care.

Chester W. Schmidt, Jr. M.D., Chief Medical Officer of Priority Partners, shared a question raised at a recent meeting of MCO medical directors as to whether there are clear rules as to the responsibilities of the MCOs for provision of behavioral health services. He underlined that the MCOs are not certain who is responsible for this care and expressed concern that the MCOs are not being compensated for the behavioral health care they are providing.

Ellen M. Weber, J.D., Vice President for Health Initiatives at the Legal Action Center, shared lessons from the recent work on network adequacy in the commercial health insurance markets. She noted that the Maryland Insurance Administration has expressed disappointment with carrier compliance. She pointed out that many of those seeking treatment find they must go out-of-network for care, which results in those individuals paying both premiums and out-of-network

costs. She added that, oftentimes, those costs get shifted from the carriers to individuals and Medicaid.

Other Business

In response to a request for details regarding the transition to a new ASO, Mr. Schrader announced that the new ASO will come to next month's meeting to address the group.

Meeting Close

The Co-Chairs thanked workgroup members for their participation.