MARYLAND
Department of Health

Notes
Behavioral Health System of Care Workgroup Meeting
October 23, 2019

Behavioral Health Administration
Dix Building

Members In Attendance

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

Introduction

The Co-Chairs welcomed members.

Discussion: Principles

The Co-Chairs began a discussion on the updated *Behavioral Health System of Care Design Quality Principles Development* document. Mr. Schrader noted that the document had undergone changes since the Workgroup's last meeting in September, including feedback from the first meeting of the Parity Discussion Group, as well as lessons learned from a recent session with the Maryland Hospital Association.

Mr. Schrader indicated that the principles document is nearly complete and stated that the next month's meeting would begin discussions of strategies to put the principles into practice. Dr. Burgess added that the staff's responsibility is to remain neutral during discussion of the principles and that no stakeholder is likely to be entirely pleased with the result.

Next, Mr. Schrader pointed out additional changes to the principles document, including the draft preamble and a rearrangement of the subheadings. In response to a request from a Workgroup member, he agreed to distribute a "redline" version of the document that shows each change.

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

- A member commented that while features of the current system's structure may have valid reasons for existing, these features should remain open for discussion. The future system should consider new ways of doing things.
- Several members commented that the document should more explicitly focus on the people the system is meant to serve.
- A member requested clarification as to whether reference to Total Cost of Care in the document refers to the state's all-payer Total Cost of Care Model or Medicaid total costs. Mr. Schrader responded that the document refers to the Total Cost of Care Model and that the definitions list will be updated accordingly.
    - In response, a member commented that total costs within the context of the Model are on a per capita basis, noting that some interventions may increase behavioral health costs, but decrease physical health costs. For example, it is inefficient to use the emergency department for behavioral health care that can be provided in an outpatient behavioral health clinic.
    - Another member noted that it is possible for the system to become more efficient and more effective yet still not cost less, since areas of the system may be underfunded and demand for services may continue to rise.
- A member commented that a large number of handoffs happen between the physical and behavioral health systems. While the physical health system has been bolstered in its ability to provide care coordination services, no such investment has been made for behavioral health. In addition, it is not clear where additional funding for such activities may be sourced.
- A member described effective, grant-funded partnerships between hospitals and the behavioral health provider community to provide care management services. Such programs disappear after the grant funding ends, and the system should be built to make such programs a permanent feature.
- Noting that outcome measures and quality are mentioned throughout the document, a member asked whether a group with clinical and research backgrounds will be assembled to develop these measures. Mr. Schrader responded in the affirmative.
- A member suggested a new principle that the system should ensure adequate availability of community alternatives to hospitalization. The principle should explicitly acknowledge the lack of alternatives to emergency departments for many seeking care.
- Some members support adding a principle of parity between substance use disorder and mental health treatment. Staff expressed concern about expanding the definition of parity beyond that set by federal policy, which requires parity between behavioral and physical health.

Mr. Schrader closed the discussion by requesting members to submit any further comments in writing and to begin thinking about options for implementing these principles.

Behavioral Health Administrative Service Organization (ASO) Overview

Rebecca Frechard, Deputy Director of the Medicaid Behavioral Health Division within the Maryland Department of Health, gave an overview of upcoming system changes with the new ASO contract with Optum, which begins on January 1, 2020. She described the primary functions of the ASO and acknowledged the compressed timeline for the transfer of functions from one contractor to another. She noted that Optum and the Department have been working together to ensure a smooth transition since June of 2019. Ms. Frechard noted that the first priority of the transition is to minimize disruption in service; the initial focus will be on authorizations, trainings on the portal, and claims processing. Mr. Schrader noted that staff are also developing an ASO manual.

Next, Ms. Frechard described the enhancements to the new contract. To bolster provider recruitment, the contract includes a requirement to identify gaps and build a plan to fill them. Additional requirements around care coordination and new audits are also included. The contract also includes new terms around reporting, data sharing, and systems to connect patients to after-care resources in the community.

Ms. Frechard then discussed the intended timeline of the transition. During the first six months, the ASO will concentrate on smooth claims and provider authorization processes, while gathering input from stakeholders on data sharing and reporting. In the second six months, the reporting and data sharing processes will be finalized. In the second year of the contract, the Department may seek budget support for new initiatives, including a provider quality incentive, the funding of services not traditionally supported by Medicaid, and a new crisis response system.

Workgroup members then had the opportunity to ask questions about the new ASO contract. In response to a range of questions, Ms. Frechard described how many systems and artifacts will transfer from the current to the new ASO, including provider files and eligibility data. However, members will need to obtain a new consent for release of information from clients, as the Department's legal counsel has advised that the existing consents cannot transfer. Noting that the original consents took a long time to secure, Workgroup members expressed concern that this would lead to gaps in care management.

A workgroup member commented that, in previous ASO transitions, residential crisis services were challenging. Ms. Frechard noted the comment and took the opportunity to introduce two key Optum Maryland staff who are experienced with Maryland services–including residential crisis—and that care will be taken to support all providers in the transition.

Ms. Frechard then introduced two representatives of the Optum Maryland ASO team—Scott Greene, Chief Executive Officer, and Dr. Lisa Hadley, Chief Medical Officer. Mr. Greene expressed admiration for the work of the Workgroup. Dr. Hadley noted that care coordination is an important part of Optum's process, and asked that interested parties communicate their ideas on these topics sooner rather than later. Ms. Frechard noted that the Department is creating a transition website and will post a running "FAQ" document. Questions related to the transition may also be emailed to mdh.bhasotransition@Maryland.gov.

Discussion: Workgroup Meeting Schedule

Mr. Schrader proposed that the Workgroup switch to meeting every other month during the upcoming legislative session, returning to monthly meetings in April 2020. The Workgroup agreed to the schedule change.

Discussion: Current System Flow Chart

Dr. Burgess presented a newly modified 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:

- Medicaid and Optum plan to resume the data feeds on high utilizers that were discontinued under Beacon.
- The flowchart should reflect some communication between the ASO and Medicaid managed care organizations (MCOs). This can be accomplished with a dotted line between the ASO and MCO boxes.
- The role of local behavioral health authorities (LBHAs) is not consistent across all the state's jurisdictions. Some LBHAs coordinate well with MCOs, while other do not.
- A member suggested the need for a process map to reflect the participant's experience navigating the system.
- Hospital emergency departments conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. Workgroup members asked for more information on these referrals.
- The flowchart should be updated to encompass the experience of those with no insurance.

Public Comment

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

Tim Santoni of the University of Maryland Systems Evaluation Center noted that the system flowchart does not contain the public health function of LBHAs. In addition, he pointed out that there is significant overlap between those dually eligible for Medicaid and Medicare and the public behavioral health system.

Maansi Raswant of the Maryland Hospital Association clarified that the bullet under cost management referring to total cost of care was specific to Medicaid rather than the broader Total Cost of Care Model, although behavioral health impacts health care delivery and costs system-wide. She also provided additional context on the data Mr. Schrader referred to earlier in the meeting. She pointed out that the information focused on high utilizers was presented based both on number of encounters and charges, without a focus on diagnosis, and also with a breakdown of top diagnoses. She agreed to share the data with the Workgroup.

Meeting Close

The Co-Chairs thanked Workgroup members for their participation.