Meeting Notes
Behavioral Health System of Care Full Workgroup Meeting
April 28, 2021

Members In Attendance

Dr. Aliya Jones, Co-Chair
Tricia Roddy, Co-Chair
Linda Raines
Lori Doyle
Ann Ciekot
Crista Taylor
Eric Wagner
Dr. Harsh Trivedi
Dr. Laura Herrera Scott
Jennifer Briemann
Dr. Yngvild Olsen

Welcome and Updates

The Co-Chairs welcomed everyone to the meeting and reviewed the agenda.

Review Project Idea Submissions

Tricia Roddy, Acting Medicaid Director and Workgroup co-chair, reported that some Workgroup members had expressed concern about how projects would be selected for the group to take on from the list of ideas, and that some wanted more time to discuss the ideas. Ms. Roddy stated that if a consensus was reached among Workgroup members on the project or projects they would be most interested in pursuing, then the staff steering committee would make the final decision. She said that today's meeting will include a discussion about proposed projects, and members were also welcomed to continue submitting comments so that the projects of most interest could be determined.

Laura Spicer, Workgroup staff, provided a recap of this Workgroup's goals and prior work:

- The reasons for the Workgroup's formation and its established goals
- The progress the Workgroup has made towards these goals

- The design principles of an improved behavioral health system of care for Medicaid participants
- The framework for operationalizing these design principles

Ms. Spicer then shared broad categories for initiatives and projects that the Workgroup can undertake, followed by projects that had been proposed by Workgroup members, Maryland Department of Health (the Department) staff, and other stakeholders, which included:

- Data sharing between Maryland Managed Care Organizations (MCOs) and the Chesapeake Regional Information System for our Patients (CRISP).
- Scaled-up implementation of the Collaborative Care Model (CoCM) pilot program.
- Launching a value-based payment (VBP) pilot.
- Improving mental health treatment for those with co-occurring substance use disorder (SUD).
- Developing comprehensive, integrated care system encompassing substance use, mental health, co-occurring disorders, and primary care.
- Developing strategies to include behavioral health providers in COVID-19 vaccination and public health education efforts.
- Obtaining input from stakeholders to determine problems they have encountered using the behavioral health system and hear their ideas on possible solutions.

Ms. Roddy facilitated a discussion of these proposed projects.

- Dr. Yngvild Olsen stated that COVID-19 vaccination by behavioral health providers had already begun thanks in part to efforts by Dr. Jones and others at the Behavioral Health Administration.
- Dr. Olsen continued that the U.S. Department of Health and Human Services put forth a new guideline recently for buprenorphine prescribing that would likely affect primary care providers.
    - Dr. Jones commented that the Behavioral Health Administration has offered support to providers who would like to newly prescribe medications for opioid use disorder such as buprenorphine. She welcomed suggestions for how to incorporate these into projects that can be pursued in the near future.
- Eric Wagner commented that the expansion of the VBP pilot is something that Workgroup member Lori Doyle has discussed multiple times here and in other meetings and he thinks it is an intriguing idea. He stated his concern is that COVID-19 has disrupted utilization patterns so making metrics associated with a VBP system could be difficult. He continued that he would like to cast a vote to keep it on the list.
    - Ms. Roddy said that agreeing upon measures and targets for a VBP system could take a while, even when there is not an ongoing pandemic, so that might be a project worth considering in the future.

- Mr. Wagner agreed with Ms. Roddy and with Ms. Doyle about using financial incentives to align somatic and behavioral health care delivery.

- Mr. Wagner asked if the proposed project to develop a comprehensive and integrated care system was intentionally worded to only include primary care and not other modalities like emergency care, urgent care, etc. He stated that hospital emergency departments (EDs) have significant behavioral health activity, and it would not be possible to pursue integration of services without including acute and emergency modalities.
    - Dr. Olsen responded that EDs and hospitals need to be included in the development of a comprehensive and integrated care system, but that this project idea was formed thinking about longer-term outcomes, like on chronic conditions and cost-savings. She continued that focusing on EDs and hospitals and not longer-term community-based systems of care would not achieve the savings and changes desired by this Workgroup.
    - Mr. Wagner agreed that lower settings of care are important, but that the role of emergency services in long-term health and financial outcomes cannot be ignored. Mr. Wagner reported that a significant proportion of emergency patients have behavioral health issues, and that the handoff from emergency care back to the community is not ideal and would be a prime area for improvement.
    - Dr. Olsen agreed with Mr. Wagner but noted that there has not been as much focus on community care or primary care compared to emergency care. She continued that many repeat visitors to the ED also have significant social determinant of health needs (e.g., housing, transportation, etc.) that the current medical system has not been set up to address. She suggested that part of this item could be exploring how Medicaid could be used as a lever in addressing social determinant of health needs.
    - Ms. Doyle commented that in other workgroups they are looking at models like the certified community behavioral health center and capitation models in Maryland that serve high-risk populations. She stated that these programs have already begun so it would not be necessary to develop a new model of care to complete this project.
    - Dr. Jones reported it might be of interest to look at what is being done across the state with warm handoffs from emergency services to community services. This could help to move towards better standardization of the handoff process to improve access to care. Dr. Jones stated that people who rely on emergency care to address behavioral health needs are not likely to receive regular preventive or primary care and tend to be harder and more expensive to care for, often resulting in poor health outcomes.

- Dr. Trivedi asked what the timeframe would be for carrying out a chosen project in terms of planning, implementation, etc. He reported that there are many needs that can and should be addressed immediately, but some projects proposed would likely take considerable time to plan.
    - Ms. Roddy responded that it would be difficult to take on large projects considering the lack of data sharing between Optum and the MCOs. She stated

that all proposed projects would produce meaningful outcomes, but a goal of the Workgroup is integration of the behavioral health and MCO communities so the project would have to be beneficial to both parties.

- Dr. Jones responded that there is no fixed timeline since some projects would necessarily take longer than others, but more than one could be pursued if desired.
- Dr. Trivedi said that was helpful and there were three key areas he believed were most important to address:
  - High-need/high-utilization clients. He stated there were likely only 1,600 or so of these clients, but there were things this Workgroup could be doing for them that would have a significant impact on the total cost of care and health outcomes.
  - Looking at innovative solutions that other states have used to address access barriers and barriers to positive outcomes, like social determinants of health.
  - Ensuring care access for those with substance use disorder and mental health conditions. He explained he was concerned by recent data from the Centers for Disease Control and Prevention that showed the largest number of opioid-related deaths since the opioid epidemic began.

- Linda Raines asked what the process would be for prioritizing these projects.
  - Ms. Roddy responded that concerns about voting on projects had been taken into consideration, so they decided to facilitate a rich discussion on proposed projects to determine if there was a consensus, with the final selection then handled by the staff steering committee.
- Mr. Wagner reported it was troubling to see overdose and suicide rates increase during the pandemic and suggested convening a group to involve more parties (e.g., acute care providers, MCOs, and behavioral health providers) to bring these rates down.
  - Dr. Jones stated there are other groups that focus on these issues and if there was not hospital provider representation on these groups then she would seek it. Dr. Jones suggested looking at coalitions and teams already doing this work and remedy the lack of representation by certain provider groups and stakeholders that could be addressed instead of starting a new group.
  - Dr. Olsen stated that it would be informative if the MCOs could give a presentation on the type of enrollee data they have so the Workgroup could get a better idea of what projects the data could be used for. Dr. Olsen continued that the proposed projects are all worthwhile, but it might be a good idea to get started on a small project that can be completed relatively quickly since many of the projects being discussed are heavy lifts.
  - Ann Ciekot reported that there has been a lot of work being done outside of this group that aligns with their goals, such as efforts to combine multiple data sources to identify high utilizers of health services. Ms. Ciekot stated that it was important to keep this group informed about what the other similar groups were doing. For a

Workgroup project idea, she suggested exploring which harm reduction and decriminalization efforts stakeholders and other organizations might support. She reported these were topics that came up in the most recent state legislative session.

  - Ms. Roddy suggested asking the MCOs to share with this Workgroup any ideas they have been considering to address issues like overdoses.

CRISP Consent Tool

Ms. Roddy introduced Adrienne Ellis of CRISP to provide a demonstration of the CRISP Consent Tool in response to a Workgroup suggestion regarding implementing a data sharing project between CRISP and the MCOs.

- Ms. Ellis provided background on CRISP and the services they provide.
- Ms. Ellis reported the Consent Tool enables patients to agree to share their protected health data between their SUD treatment providers and their other health care providers.
- CRISP went live on April 15 with Phase 1 of the Consent Tool. Ms. Ellis shared that they are in the process of testing and troubleshooting the tool as well as recruiting SUD participant sites.
- Ms. Ellis provided a demonstration of the consent tool.
  - Ms. Ellis mentioned that the consent tool is in line with 42 CFR Part 2 as it is currently and any regulatory changes that result from the CARES Act will be included later.
- Ms. Roddy stated that this tool could potentially be used to supplement the data sharing process with Optum.
- Ms. Roddy and Ms. Ellis opened the discussion for questions.
  - Dr. Olsen stated that some patients might be concerned that sharing their treatment data with payers could lead to them being denied care. Dr. Olsen asked if this was considered.
    - Ms. Roddy reported they had a much higher number of signatures with Beacon and in the past nearly all participants signed the consent form, but now the percentage is much lower. She continued that conversations were ongoing regarding how to use the CRISP Consent Tool.
    - Ms. Ellis responded that they could work on being more transparent about who sees patient data at the MCO, what exactly is seen, and how the data are used.
    - Ms. Olsen stated that being clearer about how the data are used and how data sharing can be helpful to patients would be beneficial.

- Ms. Ellis provided her contact information and encouraged attendees to reach out with more questions.

Collaborative Care Model

Ms. Roddy introduced Alyssa Brown, Deputy Director of the Medicaid Office of Planning, to provide an overview/update on the CoCM pilot project.

- Ms. Brown provided a general overview of the CoCM pilot and provided a brief update on implementation.
- Ms. Brown described the enabling legislation and goals of the CoCM.
- Ms. Brown described how the providers involved in delivering care in the CoCM interact with each other.
- Ms. Brown described service delivery of the CoCM, including billing codes and reimbursement.
    - Ms. Brown reported that reimbursement through the pilot project is limited to services delivered to Medicaid enrollees only.
- Ms. Brown described the CoCM pilot program timeline.
- Ms. Brown stated the current pilot awardee is Privia Medical Services and Mindoula Health, and they provide CoCM services at 12 sites across three focus areas:
    - Urban: these sites tended to serve populations that have been historically harder to reach, including people whose primary language is not English.
    - Rural: these sites were chosen in part because they had telehealth capabilities.
    - OB/GYN: this was chosen as a focus area because of the high prevalence of postpartum depression among women with low income.
- Ms. Brown shared figures on enrollment, including participants per quarter, the number who have completed treatment (93), and the average enrollment span for those who have completed treatment (80 days). She reported that outcomes evaluations are in the preliminary stages, but they are awaiting final language in the Joint Chairmen's Report that may require a report to be submitted in November 2021.
- Ms. Roddy suggested presenting the evaluation of CoCM to this group when it is completed.

Public Comment

Due to time constraints, there were no public comments, but all attendees were encouraged to submit questions or comments to Laura Spicer at lspicer@hilltop.umbc.edu.

Meeting Close and Next Steps

The System of Care Discussion Groups will continue to remain on hold and the next Workgroup meeting has yet to be scheduled.

Ms. Spicer reported that the Department is conducting a health information technology environmental scan survey as part of required closeout activities for the Maryland Medicaid Electronic Health Record (EHR) Incentive Program. This program helped fund health information technology for eligible providers to purchase and adopt EHR technology and offered some incentive payments. The purpose of the survey is to gather information about the adoption, meaningful use, and interoperability of EHR systems, the Health Information Exchange (HIE) capabilities/interests, and the Health IT landscape in Maryland. The Department would like to gain information and insights regarding experiences and perceptions about the EHR Incentive Program. The online survey is expected to open Wednesday, May 12, 2021, and will remain continuously open until it closes on Wednesday, June 9, 2021. Providers participating in this meeting were encouraged to complete the survey once it is available.