Behavioral Health System of Care Workgroup

August 22, 2019
Purpose: To synthesize principles and build consensus around design components for a system of care.
Meeting Schedule

Meeting 1
Date: Wednesday, July 31
Time: 9:00 a.m. to 12:00 noon
Meeting Room: L3
Orientation

Meeting 2
Date: Thursday, August 22
Time: 9:00 a.m. to 12:00 noon
Meeting Room: L1
Discuss Principles

Meeting 3
Date: Thursday, September 26
Time: 9:00 a.m. to 12:00 noon
Meeting Room: L4
Consensus on Principles

Meeting 4
Date: Wednesday, October 23
Time: 9:00 a.m. to 12:00 noon
Meeting Room: L2
Discuss Options

Meeting 5
Date: Thursday, November 21
Time: 9:00 a.m. to 11:00 a.m.
Meeting Room: L2
Consensus on Options

Meeting 6
Date: Monday, December 16
Time: 1:00 p.m. to 3:30 p.m.
Meeting Room: L4
Report and Next Steps
Design Team

Senate-Finance-Committee

House-Health-and-Government-Operations-Committee

Steering-Committee
- Robert Neall, Secretary
- The Honorable Deores G. Kelly, Chair, Senate Finance Committee
- Delegate Robyn Lewis, House Health and Government Operations Committee
- Dennis R. Schrader, Chief Operating Officer and Deputy Secretary for Health Care Financing
- Lisa A. Burgess, MD, Acting Deputy Secretary of Behavioral Health Administration
- Jennifer McVain, Director of Finance for Medicaid
- Tricia Roddy, Director, Office of Innovation, Research, and Development
- Jill Spector, Director of Medical Benefits Management
- Cynthia Pecon, Deputy Director of Systems Management, BHA

STAFF
BHA-Medicaid

Working-Group
w/ Chair and Representatives from Discussion Group
The Working Group is designed to bring together individuals possessing the relevant knowledge and skills who will act either individually or collectively to undertake assigned tasks and activities in order to achieve the project's objectives.

Project Manager
Lead "contracted" by the Steering Committee to ensure the work of the project is undertaken as agreed, whereas the Steering Committee provides support, guidance, and the executive oversight of progress.

Stakeholders: Discussion Groups

Behavioral Health Community
Managed Care Organizations (MCOs)
Maryland Hospital Association
Parity
Discussion: Principles and Values
Three Design Components

1. Quality Integrated Care Management
2. Cost Management
3. Behavioral Health Provider Management and Network Adequacy
Principles Overview

- Reflect Workgroup discussions and written submissions to date
- Do not necessarily reflect consensus
- Still a work in progress
## Quality Integrated Care Management

<table>
<thead>
<tr>
<th>Person-Centered/ Family-Focused</th>
<th>Oversight &amp; Accountability</th>
<th>Data Sharing &amp; Outcomes Measurement</th>
<th>Continuum of Care</th>
<th>Social Determinants of Health (SDOH)</th>
<th>Parity</th>
<th>Other</th>
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<tbody>
<tr>
<td>Culturally and linguistically appropriate</td>
<td>Clear lines of authority and responsibility</td>
<td>Data sharing, e.g. through CRISP</td>
<td>Seamless care across the age spectrum (children, adolescents, adults)</td>
<td>Focus on SDOH, a key driver of outcomes</td>
<td>Comply with federal and State laws</td>
<td>Harmonize MH and SUD treatment</td>
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<td>Promotes equity</td>
<td>Transparent oversight</td>
<td>Use technology to track outcomes</td>
<td>Creative use of funding to address SDOH</td>
<td>Prioritize BH equally w/ physical health care</td>
<td>Evidence-based treatment</td>
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<td>Accounts for regional variation</td>
<td>Cross-agency coordination</td>
<td>Embed outcome measurement in the design</td>
<td>Full range of care – prevention, early intervention, treatment, rehabilitation, recovery support to address needs as they fluctuate</td>
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<td>BH in primary care setting &amp; PC in BH setting</td>
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<td>Involves clients in design, goals, plans</td>
<td>Involves community stakeholders as equal partners</td>
<td>Medication adherence</td>
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<td>High utilizer management</td>
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<td>Treatment in least restrictive environment possible</td>
<td>Bridges integration barriers and silos</td>
<td>Sobriety relapse</td>
<td>Locations of care – facility-based and outreach services and supports</td>
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<td>Combine chronic disease mgmt. w/ early detection/time-limited intervention</td>
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<td>Devote additional resources to data collection and analysis</td>
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Cost Management

• Incentivize:
  • Positive outcomes
  • Provider-to-provider and provider-to-agency (education, housing, justice, etc.) communication and coordination

• Flexible reimbursement rules – value-based, pay-for-performance, risk-sharing, capitation

• Design for innovation in delivery models (e.g., CCBHC)

• Reinvest savings from health reform into the public BH system
# Provider Management & Network Adequacy

<table>
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<tr>
<th>Quality</th>
<th>Workforce</th>
<th>Access</th>
<th>Safeguards</th>
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<tr>
<td>Providers proven to be of high quality</td>
<td>Minimize duplicative admin burden</td>
<td>Include mental health &amp; addiction counseling</td>
<td>Grievance and appeals process</td>
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<td>Define a “qualified provider”</td>
<td>Design for workforce pipeline (students, trainees, etc.)</td>
<td>Maintain safety net</td>
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<td>Design for both programs and independent practices</td>
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<td>Adequate reimbursement</td>
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Parking Lot: Maintain seamless care for individuals churning in and out of Medicaid
Public Comment
Next Steps

The next meeting will be:

Date: Thursday, September 26
Time: 9:00-12:00
Meeting Room: MDH L4