



MARYLAND
Department of Health

Notes
Behavioral Health System of Care Workgroup Meeting
December 16, 2019

Behavioral Health Administration
Dix Building
Spring Grove Hospital Center
Catonsville, MD 21228

Members In Attendance

Dennis Schrader, Co-Chair	Eric Wagner
Lisa Burgess, Co-Chair	Harsh Trivedi
Linda Raines (by phone)	Laura Herrera Scott
Lori Doyle (by phone)	Barbara Brookmeyer for Gregory Branch
Ann Ciekot	Yngvild Olsen
Adrienne Briedenstine for Crista Taylor	Arethusa Kirk
Vickie Walters	

Introduction

Dr. Lisa Burgess, Acting Deputy Secretary of the Behavioral Health Administration (BHA) and Medicaid Chief Medical Officer and Dennis Schrader, Medicaid Director and Chief Operating Officer of the Maryland Department of Health (the Department) welcomed members to the meeting. Mr. Schrader and Dr. Burgess described the System of Care legislative briefing, which occurred on December 10. The Delegates present during the briefing were supportive of the System of Care process to date, and no public comments were offered.¹

Medicaid Scorecard

Alyssa Brown, Deputy Director of the Office of Innovation, Research, and Development at the Department, gave the Workgroup an overview of the Medicaid Scorecard, a group of measures used by the Centers for Medicare & Medicaid Services (CMS) to evaluate the effectiveness of the states in achieving a range of goals through their Medicaid programs. She explained that

¹ The report is available here:
<https://mmcp.health.maryland.gov/Documents/BH%20System%20of%20Care/12.10.2019%20MDH%20System%20of%20Care%20Update%20to%20HGO.pdf>

Maryland's performance on these measures has been quite good, adding that the 2019 Scorecard will contain Maryland reporting of five out of the eight current behavioral health measures.

In response to a question from a Workgroup member, Ms. Brown explained that the scorecard does not present any target figures. Rather, it collects the data from each state and compares each state's performance against the median performance of all states. Mr. Schrader added that he believes CMS is moving toward a system whereby they collect raw data from the states and do their own reports.

Ms. Brown continued describing the measures in the scorecard that relate to behavioral health, explaining that, under the domain of *Promote Effective Prevention & Treatment of Chronic Diseases*, the scorecard includes 14 measures, of which 2 are behavioral health-related with 1 additional behavioral health measure to be added in the future. After some discussion among Workgroup members about the definition of terms in the scorecard, Ms. Brown indicated that she would share the technical specifications for the measures with the group.

Ms. Brown then described the other types of information captured in the scorecard, under the headings of State Administrative Accountability and Federal Administrative Accountability. She explained how the system will evolve in the future, including relying less on state reporting and more on CMS directly analyzing raw data submitted by states.

Discussion – Framework for Improvements to Operationalize the Design Principles

Mr. Schrader asked Workgroup members to respond to the draft framework document. He noted that the number of categories expanded from six to eight since the last Workgroup meeting. The new categories of Participant and Treatment Experience Improvements and Parity Improvements, as well as the previously existing categories, each now have a goal statement.

Mr. Schrader asked Workgroup members to focus on the Cost Management Improvements category, particularly the goal statement. The ensuing discussion included the following:

- A Workgroup member commented that many of the shortfalls in the provision of behavioral health care are not limited to the public system. Rather, they are endemic to the entire system regardless of payer.
- Another member noted that the challenges of addressing the co-occurring population's needs include regulatory barriers, such as licensure and scope of practice limitations, administrative barriers around payment for services, as well as other workforce issues including the content of training curricula for professionals.

Mr. Schrader asked Workgroup members to respond to the proposed goal, under the Participant Experience Improvement category: "to assure that behavioral health participants receive outstanding customer service." The Workgroup discussed the use of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to assess managed care organization (MCO) performance. Dr. Burgess added that the ASO conducts a behavioral health satisfaction survey.

Mr. Schrader then asked Workgroup members to provide input on the Parity Improvements category. Workgroup members discussed the following:

- A member commented that case management in the managed care medical system is provided at the MCO level, while case management in the behavioral health system is done at the provider level. The member suggested that there might be a parity issue around case management.
- A member commented that system improvements should be built to mirror the scorecard structure, including explicitly linking the scorecard measures to any improvement. Specifically, goals should be pegged to above-median performance on the Medicaid scorecard measures.
- Workgroup members would like to see Maryland's performance on the Medicaid Scorecard measures going forward.

Data Sharing Improvements

Mr. Schrader then moved the discussion to improvements in data sharing. Workgroup members discussed the following:

- A member noted that the Prescription Drug Monitoring Program (PDMP) data are subject to a number of legislatively mandated controls on access. Any changes to access to PDMP data may need to be made through legislation and/or regulation.
 - A member commented that two states currently have data sharing between their PDMPs and their MCOs and may provide a model for Maryland.
- A member noted that Dartmouth University has published tools to assess providers' ability to treat individuals with co-occurring mental and behavioral health issues. These tools might be useful in Maryland's improvement effort.
- A member commented that the Governor's Commission to Study Mental and Behavioral Health is working to address crisis services in Maryland. While some outpatient mental health clinics (OMHCs) offer substance use disorder services, there may be room to expand the availability of crisis services in such facilities.
 - Another member noted that the population in need of crisis services is a subset of those who need specialty behavioral health services. The characteristics of that subset must be better understood so that services can be designed to meet their needs.
- A member suggested that the Department document the "care journeys" of participants from their various entry points through their treatment.

Behavioral Health Provider Network Improvements

Next, Mr. Schrader asked the Workgroup to share their thoughts on improvements to behavioral health provider networks. He particularly called attention to the fact that the state is responsible

for building the behavioral health provider network, unlike in the medical program where MCOs build the networks. The Workgroup discussed the following:

- Several members suggested that the any willing provider standard should be improved to any willing *and qualified* provider.
- A member commented that, even in the physical medicine system, it is challenging to remove a low quality provider.
- A member commented that licensure and accreditation may not suffice to qualify providers for the behavioral health system.
- Staff noted that any system by which providers are removed from the network due to quality concerns must match the system used by the MCOs. To have a different system would raise parity concerns.
- A member noted that efforts to limit the number of low quality providers in the system must be weighed against the fact that behavioral health providers are understaffed already. In counterpoint, another member commented that the use of a low quality provider should not be defined as meeting a need.
- Members discussed that the system should work out how to define success and over what time period to make such an assessment.
- Members discussed that the workgroup should analyze the provider mix of the system's dollars paid and determine whether the money is going to the right professionals.

Out of Scope

Finally, Mr. Schrader reviewed some suggested improvements that are outside the scope of the Workgroup and are more properly the domain of the Commission to Study Mental and Behavioral Health in Maryland. The Workgroup discussed the following:

- A member suggested that the Chesapeake Regional Information System for our Patients (CRISP), Maryland's Health Information Exchange, is a possible repository for patient experience and customer satisfaction survey results.
- A member commented that, while social determinants of health remain an important focus of any healthcare related effort, the public behavioral health system is not necessarily, for example, an environment well suited to address housing instability.

Public Comment

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

Andrea McDonald-Fingland, Director of the Calvert County Local Behavioral Health Authority, underlined her region's barriers to effective treatment, including cost of living and proximity to other regions. She expressed concern over the idea of limiting providers, noting her fear that no behavioral health providers would remain in her county. She encouraged the Workgroup to take a regionally-specific approach to any quality improvement efforts.

A member of the public who did not share their identity, but described themselves as a longtime advocate for behavioral health, expressed admiration of and support for the local Behavioral Health Authority in Anne Arundel County.

Meeting Close

The Co-Chairs thanked Workgroup members for their participation. They announced that the Workgroup would next meet on February 12, 2020.