



**MARYLAND**  
Department of Health

**Meeting Notes**  
**Behavioral Health System of Care Workgroup Meeting**  
**9:00 AM-12:00 PM July 31, 2019**

Maryland Department of Health, L3 Conference Room  
201 W. Preston Street  
Baltimore, MD 21201

**Members in Attendance**

Dennis Schrader, Co-Chair  
Lisa Burgess, Co-Chair  
Linda Raines  
Lori Doyle  
Ann Ciekot  
Crista Taylor  
Vickie Walters

Eric Wagner  
Harsh Trivedi  
Jocelyn Bratton Payne (by phone)  
Laura Herrera Scott  
Yngvild Olsen  
Jan Desper-Peters  
Gregory Branch

**Members Absent**

Karin Neufeld

**Welcome and Introductions**

The Co-Chairs welcomed the members of the workgroup and thanked them for their participation. After noting that the meeting is public and being recorded, members of the workgroup introduced themselves to one another.

**Workgroup Overview**

The Co-Chairs provided background information regarding the purpose of the workgroup, which is to synthesize principles and build consensus around the design components for a system of care.

Mr. Schrader then explained the expected milestones of the workgroup. The House Health and Government Operations and Senate Finance Committees of the Maryland General Assembly will be briefed on the workgroup's progress in December, by which time the Co-Chairs intend to have a set of principles in place. The total duration of the workgroup's service is expected to be two years.

The Co-Chairs described the workgroup's function within the broader context of efforts to improve the statewide behavioral healthcare system. The task of setting the public behavioral health rates, as required by the 2017 Heroin and Opioid Prevention Effort and Treatment (HOPE) Act<sup>1</sup>, is underway, and a work plan and implementation strategy are expected by December 2019. In addition, the recently-created Governor's Commission to Study Mental and Behavioral Health will tackle behavioral health care in Maryland, statewide, and will involve commercial payers. The workgroup, therefore, must remain focused on its charge, while the Governor's Commission is examining the statewide behavioral health environment.

Next, the Co-Chairs described three design components in the work plan: quality integrated care management, cost management, and behavioral health provider management and network adequacy. They noted the developments in provider management and network adequacy in recent years and that, while further improvements can be made, the efforts have been helpful. By contrast, less advancement has been realized on the other two components. The majority of the workgroup's task over the next six months will be to develop design principles around these three components.

The Co-Chairs then gave an overview of the stakeholder discussion groups that will inform the workgroup's deliberations, including the Medicaid managed care organizations (MCOs), the behavioral health provider community, the Maryland Hospital Association, and a group focused on parity. They emphasized that participation on the workgroup will be a major time commitment. However, many people and organizations wanted to participate, but were not able to do so, in order to keep the workgroup's size manageable in which quality discussions and consensus building could occur.

The Co-Chairs concluded by explaining the workgroup's scope of work and ground rules:

- The scope of work is the current system.
- The goal is to develop recommendations for the Senate Finance and Health and Government Operations Committees.
  - Recommendations will be developed through a consensus process, but options and dissenting/minority opinions will be presented to the Committees.
- The workgroup should be open to new ideas.
- Discussions will be limited to workgroup members. Opportunity for public comment will be provided at the end of all meetings.

Workgroup members were then asked to offer their comments and questions. The ensuing discussion surfaced the following:

- Once the workgroup makes its recommendations to the legislative committees, the General Assembly will ultimately decide what actions will be taken.
- The scope of work being the current system is interpreted to mean finding ways to improve the quality, cost, and access of the current package of services, without adding

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<sup>1</sup> Available here: [http://mgaleg.maryland.gov/2017RS/chapters\\_noln/Ch\\_571\\_hb1329E.pdf](http://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_571_hb1329E.pdf).

new services. Workgroup members suggested changing the language from “current system” to “current body of services.”

- The scope of work does not extend to public behavioral health hospitals. It will remain focused on quality, cost, and access within the Medicaid managed care population. While these issues have drivers and effects outside of managed care, those cross-cutting elements are to be addressed by the Governor’s Commission.
- Any idea is potentially on the table, but the workgroup will not start from a solution then work backwards. The mission is to begin with design principles then move toward a solution.
- Workgroup members requested sufficient data to inform their discussions, ranging from a clear catalog of the services under discussion to demographic data on the population served.

## **Discussion: Principles and Values**

The Co-Chairs began a discussion of principles and values, asking that workgroup members not only share their thoughts at the meeting, but also provide them in writing to staff in order to facilitate future discussions. Please note that the following statements do not necessarily reflect workgroup consensus, but a catalogue of topics discussed:

- The system should be person-centered.
- The system should promote equity of gender, race/ethnicity, creed, and sexual orientation.
- Treatment of mental health and substance use disorders should have equal priority with physical health care.
- The system should focus on social determinants of health, since many behavioral health outcomes are driven by them.
- The system should encourage the use of evidence-based treatment.
- The system should have clearly defined responsibilities across the various regulatory and accrediting authorities and transparent oversight.
- The population receiving services under the system often cycle into and out of other systems of care, making it necessary to improve accessibility and flexibility.
- Within the realm of behavioral health, there is much work to do to fully harmonize mental health and substance use disorder treatment.
- All participants in the system must avoid judgmental, stigmatizing language and practices in order to adequately address the population in need. The system must be welcoming and comfortable to those receiving services.
- The system should be flexible enough to offer services tailored to needs that might differ across the various regions of the state.

- The system should not be compartmentalized by the age—there should be a continuum of care available through childhood, adolescence, and adulthood.
- The system should be set up to incentivize positive outcomes for those receiving services, and should be flexible enough to modify those incentives toward that end.
- Providers in the system should be proven to be of high quality. The system should allow for continuous quality improvement.
- The system should operate on the understanding that chronic disease management is critical to success.
- The system should be able to adapt to innovations in treatment.
- The system should be flexible enough to allow for behavioral health treatment in the primary care setting, as well as primary care in the behavioral health setting, as dictated by the needs of those receiving treatment.
- Data sharing, such as through the Chesapeake Regional Information System for Our Patients (CRISP), should be optimized to improve care coordination.
- The system’s payment structures should incentive the desired behaviors/outcomes.

The Co-Chairs reiterated their request that workgroup members submit their ideas in writing, even though they were discussed in the meeting.

### **Discussion: Pros and Cons of the Current Public Behavioral Health System**

The Co-Chairs invited workgroup members to share their thoughts on both the positive and negative aspects of the currently-existing system. Please note that the following statements do not necessarily reflect workgroup consensus, but a catalog of topics discussed. In the ensuing discussion, the following were mentioned as the existing system’s good points:

- Maryland has a diversity of services and care access as compared to other states.
- Maryland has a commitment to continuous care, regardless of insurance status.
- Local providers play a strong role in the system.

The challenges of the existing system discussed by the workgroup included:

- The payment structure lacks flexibility.
- The relationship between the physical and behavioral health systems is not well established and may fail to link those who need care with the appropriate resources.
- There is a lack of information about the quality of services provided and quality assessment standards.
- Some behavioral health care providers are behind the curve in information technology.
- The distribution of care facilities does not match the distribution of need for services. Sometimes this is caused by local zoning.

- The system is vulnerable to commercial payers' failure to implement parity, leading to overburdening of the public behavioral health system.
- Parity issues need attention.
- Provider network management standards could be stronger, including defining a "qualified" provider.

## **Public Comment**

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

Dr. Nancy Rosen-Cohen, Executive Director of the Maryland Chapter of the National Council on Alcoholism and Drug Dependence, encouraged the workgroup to focus on recovery support services. She explained that treatment providers have been doing good work in Maryland, but that the people they treat also need such wraparound services as case management, employment and job coaching, and assistance with access to government services.

## **Meeting Close**

The Co-Chairs thanked workgroup members for their participation.