

MARYLAND BEHAVIORAL HEALTH COALITION

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Recommendations for Improving Maryland's **Public Behavioral Health System of Care**

Following debate during the 2019 legislative session about the structure of Maryland's public behavioral health system, the Maryland Department of Health has embarked on a process to examine and make recommendations on how the state should provide, administer and finance public mental health and substance use services. The initiative aims to identify solutions that increase the coordination and quality of somatic and behavioral health care for Medicaid enrollees, ensure cost efficiencies, and promote access to care. The process has been structured to address **five stated principles**:

1. Quality Integrated Care Management
2. Oversight and Accountability
3. Cost Management
4. Access to Behavioral Health Services through Provider Administration and Network Adequacy
5. Parity

The Maryland Behavioral Health Coalition welcomes the opportunity to partner with the state in this effort. Maryland's current public behavioral health system is nationally recognized as a clinically effective and cost-efficient model. However, we realize there is room for improvement. Accordingly, the 76 undersigned organizations of the Behavioral Health Coalition are united in support of the following strategies as the best options for improving care, efficiency and outcomes for the public at this time. All of these recommendations can and should be implemented now, concurrent with the ongoing process.

Implement uniform and systemwide measurement-based care standards for mental health and substance use disorders *(Principles Addressed: 1, 3, 4)*

Measurement of symptoms and care effectiveness have lagged in the behavioral health field due to an absence of lab tests or other definitive clinical measures for mental health and substance use disorders, but this has changed in recent years. Validated symptom rating scales for behavioral health assessment and treatment are available. Federal policy has increasingly incentivized and mandated their use, and accreditation bodies like the Joint Commission require providers to have such tools in place by 2020.

Robust measurement of outcomes ensures that consumers receive quality health care services and that policy decisions are informed by data. Broad adoption of measurement-based care across health systems should serve as a critical first step to any large-scale systems change. The state should create incentives to help providers adopt uniform measurement-based outcome tools.

Improve the quality and cost predictability of care by expanding value-based payments in behavioral health. Ensure care is patient-centered by increasing provider flexibility and expanding value-based, outcome-focused service delivery across systems *(Principles Addressed: 1, 2, 3, 4, 5)*

Movement toward value-based, outcome-focused service delivery can strengthen capacity for high-quality services in the publicly-funded behavioral health system by letting outcomes drive provider reimbursement. To migrate Maryland's public behavioral health system to a value-based purchasing model, we recommend that the state adopt a three-step path to building capacity to expand value-based payment methodologies as follows:



Moving judiciously to test new specialty care payment and service delivery models, in parallel with refinement of rigorous outcome measurement and oversight mechanisms, will enable Maryland to put patient experience and outcomes first, stabilize Maryland's specialty provider network during a period of intense nationwide workforce shortage, improve the quality of care, and avoid the service disruption experienced in other states.

Integrate and better define roles and responsibilities for local system management agencies
(Principles Addressed: 1, 2, 3, 4)

Local system management and planning agencies (LBHAs, CSAs, LAAs) play a key role in Maryland's public behavioral health system, overseeing and coordinating access to behavioral health services and supports to address the particular needs and gaps in their community. But the lines of authority and responsibility for system oversight are unclear across jurisdictions, providers, and relevant local, state and federal agencies. This creates overlap and duplication of effort and access barriers for the public. These challenges can be compounded in some jurisdictions by the continued existence of separate local mental health and substance use authorities.

Ongoing state efforts to integrate and regionalize mental health and substance use planning and management functions must continue. Additionally, efforts should be made to define and clarify the role and authority for local system management agencies to ensure there is active and consistent oversight of behavioral health providers and access to a full range of behavioral health services in the community.

Increase management of the behavioral health provider network and ensure the appropriate enforcement of current regulations (*Principles Addressed: 1, 2, 3, 4*)

Maryland's current 'any willing provider' model increases service availability and access, but it also allows for the participation of a small number of providers with noncompliant billing practices and substandard quality. Unfortunately, rather than discipline or shutter bad actors and fraudulent providers, the practice has too often been to eliminate services broadly, cut reimbursement rates, or enact overly burdensome regulations on *all* providers.

An increased focus on outcomes, better management of the provider network, and appropriate enforcement of current regulations can increase quality and decrease inappropriate and excessive billing by less invested and noncompliant providers. Staffing and resources should be increased as necessary to effectuate this stronger regulatory enforcement, but it should also be accompanied with an increased transparency in regulatory processes and greater due process for providers.

Make better use of health information systems to improve data sharing (*Principles Addressed: 1, 2*)

A key to success for the recommendations above – whether it's the expanded use of measurement-based care, more value-based payment arrangements, or better system coordination – is the smarter use and broader availability of quality health data. Maryland is fortunate to have the Chesapeake Regional Information System for our Patients (CRISP), one of the most innovative and effective health information exchanges in the country, but the state is not making optimal use of data that can help drive decision-making and guide clinical care.

The Maryland Department of Health's data information system is sorely in need of modernization and enhancement, which requires a capital investment. An optimal data system would include mental health and substance use disorder information – with strict compliance to HIPAA and 42 CFR Part 2 standards – and be integrated at the state, local and provider levels. The system should interface seamlessly with CRISP and ensure routine and effective data sharing across all sectors, including behavioral and somatic health providers, vendors, relevant government agencies and the public. Behavioral health providers should receive assistance in optimizing their electronic health records, and behavioral health consumers should receive regular notice of their rights with respect to the sharing of their personal health data.

Improve the capacity of the Medicaid managed care system to integrate with non-Medicaid state systems, populations and services (*Principles Address: 1, 2, 3*)

Maryland's public behavioral health system is broader than just the Medicaid managed care population. Changes made in one area will affect other areas. Health outcomes improve and medical costs decrease when Medicaid services are seamlessly integrated with non-Medicaid services such as housing, criminal justice, employment, state psychiatric hospital care, education, and behavioral health services for individuals who churn in and out of Medicaid eligibility. A holistic, integrated approach is more clinically effective, increases cost savings for the state, and prevents cost-shifting to non-Medicaid systems.

As the state looks to restructure its Medicaid managed care system, it must consider how critical, non-Medicaid populations and services are integrated into the model. These include uninsured and underinsured individuals, those dually eligible for Medicaid and Medicare, older adults, children, residential rehabilitation programs, recovery services, crisis services, etc. This integration could be improved even more if state agencies are encouraged and rewarded for initiatives that integrate care and reduce costs from an inter-agency perspective.

Adoption of the transformational strategies above would greatly enhance the delivery of behavioral health care across Maryland and further the state's standing as a leader in the field. These recommendations enjoy the support of the following organizations:

Baltimore City Substance Abuse Directorate
Baltimore Crisis Response, Inc. (BCRI)
Behavioral Health Coalition of the Mid/Eastern Shore
Behavioral Health System Baltimore (BHSB)
Board of Child Care
Carroll County Youth Service Bureau
Catholic Charities of Baltimore
Center for Children
Chesapeake Voyagers
Community Behavioral Health Association of Maryland (CBH)
Cornerstone Montgomery
Corsica River Mental Health Services
Crossroads Community
Disability Rights Maryland
EveryMind
Garrett County Lighthouse
Greenbelt Youth Services Bureau
Health Care for the Homeless
Healthy Harford / Healthy Cecil
Hearts and Ears
Helping Other People through Empowerment (HOPE)
HOPE Station
Hudson Health
Institutes for Behavior Resources/Recovery Enhanced by Access to Comp. Healthcare (IBR/REACH)
Instruments of Healing
Key Point Health Services
Laurel Youth Services Bureau
Legal Action Center
Lighthouse, Inc.
Lower Shore Friends
Maryland Association of Behavioral Health Authorities (MABHA)
Maryland Association of Nonpublic Special Education Facilities (MANSEF)
Maryland Association for Partial Hospital and Intensive Outpatient Programs
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Clinical Social Work Coalition (MCSWC)
Maryland Coalition of Families (MCF)
Maryland Coalition on Mental Health and Aging
Maryland – DC Society of Addiction Medicine (MDDCSAM)
Maryland Nonprofits

Maryland Psychiatric Society (MPS)
Maryland Psychological Association (MPA)
Maryland Rural Health Association (MRHA)
Mental Health Association of Maryland (MHAMD)
Mental Health Association of Frederick County
Mid Shore Behavioral Health
Montgomery County Federation of Families for Children's Mental Health
National Alliance on Mental Illness, Maryland (NAMI)
NAMI Anne Arundel County
NAMI Carroll County
NAMI Frederick County
NAMI Harford County
NAMI Howard County
NAMI Kent and Queen Anne's County
NAMI Lower Shore
NAMI Metro Baltimore
NAMI Montgomery County
NAMI Prince George's County
NAMI Southern Maryland
National Association of Social Workers, Maryland (NASW)
National Council on Alcoholism and Drug Dependence, Maryland (NCADD)
Office of Consumer Advocates
On Our Own of Maryland
On Our Own of Baltimore
On Our Own of Calvert County
On Our Own of Carroll County
On Our Own of Cecil County
On Our Own of Howard County
On Our Own of Montgomery County
On Our Own of Prince George's County
On Our Own of St. Mary's County
PDG Rehabilitation Services
Peer Wellness and Recovery Services
Pro Bono Counseling Project
Prologue
Sheppard Pratt Health System
Southern Maryland Community Network