HB48 - Collaborative Care Testimony.pdf
Uploaded by: Abigail Snyder
Position: FAV

BALTIMORE JEWISH COUNCIL

Written Testimony
House Bill 48 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion
Health and Government Operations Committee – February 7, 2023

Support

Background: House Bill 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

Written Comments: The Baltimore Jewish Council represents The Associated: Jewish Federation of Baltimore and all of its agencies. This includes Jewish Community Services (JCS), which offers programs and services for people of all ages and backgrounds, helping them achieve their goals, enhance their wellbeing, and maximize their independence. JCS' experienced licensed clinical social workers, counselors, psychologists, and psychiatric providers currently provide therapy and medication management to a large population of clients with both commercial and public insurance. Over 180 of these clients have Medicaid (this is a subset of the total number of clients treated).

In addition to therapy and medication management services, JCS has implemented Patient Care Connection (PCC), a grant-funded model with many similarities to Collaborative Care. Through PCC, JCS currently serves 99 clients with the potential to serve many more. In anticipation of the grant termination, JCS is planning to transition the Medicare clients to a CoCM model to maintain continuity of care. Clients with Medicaid, however, may face termination if the legislature does not pass Senate Bill 101 expanding Medicaid coverage to CoCM. This outcome would be detrimental to current and future Medicaid clients who benefit greatly from these services.

CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings. It has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

By integrating behavioral health care into primary care, patients consistently demonstrate improved mental health and compliance with medical regimens; therefore, yielding improved health outcomes, reducing unnecessary hospitalization or higher intensity levels of care, and saving healthcare costs. **For these reasons, the Baltimore Jewish Councils asks for a favorable report on HB48.**

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of The Associated Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

BALTIMORE JEWISH COUNCIL
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Member of the Jewish Council for Public Affairs

HB0048_The Arc Maryland_Support.pdf
Uploaded by: Ande Kolp
Position: FAV

The Arc Maryland
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410-571-9320

HB0048 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion
House Health and Governmental Operations Committee
February 7, 2023

Position: Support

The Arc Maryland is the largest statewide advocacy organization dedicated to protecting and advancing the rights and quality of life of people with intellectual and developmental disabilities.

We support HB0048 because we believe it will add one more tool to a package of measures we hope pass into law this session, designed to effectively address the Behavioral Health community capacity crisis in Maryland and improve coordination of care across disciplines.

The Collaborative Care Model is an evidence–based approach for integrating somatic and behavioral health services in primary care settings. The approach includes: (1) Care coordination and management; (2) Regular, proactive outcome monitoring and treatment for outcome targets using standardized outcome measurement rating scales and electronic tools, such as patient tracking; and (3) Regular systematic psychiatric and substance use disorder caseload reviews and consultation with a psychiatrist, an addiction medicine specialist, or any other behavioral health medicine specialist as allowed under federal regulations governing the model.

We appreciate the sponsors work on this bill, and respectfully ask for a favorable report from the committee on HB0048.

Sincerely,

Ande Kolp
Executive Director
akolp@thearcmd.org, 443-851-9351, www.thearcmd.org

HB48 - Adventist HealthCare - FAV.pdf
Uploaded by: Andrew Nicklas
Position: FAV

Adventist HealthCare

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

February 7, 2023

To: The House Health and Government Operations Committee

From: Adventist HealthCare

Re: HB48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

POSITION: SUPPORT

Adventist HealthCare operates the state's largest clinically integrated network of community providers, including primary care practices, and is the second largest provider of behavioral health care in Maryland. We know firsthand the value of integrating behavioral health services with primary care and fully support permanently establishing the Collaborative Care Model (CoCM) in Maryland.

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Avoiding hospitalization will provide needed relief to Maryland's network of inpatient behavioral health services. This system is strained meeting the current demand for services. Expanding access to care at an earlier stage to avoid acute, high intensity episodes supports patients and providers. Maryland insurers are already reimbursing providers for delivering this model and the Medicaid pilot program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. For these reasons Adventist HealthCare supports HB48 and encourages the committee to give a **favorable report**.

MD Addiction Directors Council - 2023 HB 48 FAV -
Uploaded by: Ann Ciekot
Position: FAV

Maryland Addiction Directors Council

House Bill 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

House Health and Government Operations Committee

February 7, 2023

TESTIMONY IN SUPPORT

Maryland Addiction Directors Council represents SUD and Dual Recovery outpatient and residential providers in Maryland. MADC members provide over 1,200 residential beds across the State and advocate for quality SUD and Dual Recovery outpatient and residential treatment.

MADC supports HB 48, which will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated “clinically significant improvement” in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

MADC believes CoCM provides an important, evidence-based source of treatment for Maryland Medicaid clients. The Covid pandemic saw a significant increase in the need for behavioral health treatment while drug overdose continues to claim the lives of Marylanders. All avenues to integrated treatment should be mobilized to provide treatment and save lives.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. **For these reasons, Maryland Addiction Directors Council urges this committee to pass HB 48.**

HB 48_Maryland Coalition of Families_Fav.pdf
Uploaded by: Ann Geddes
Position: FAV

HB 48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

Committee: Health and Government Operations
Date: February 7, 2022
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

MCF strongly supports HB 48.

HB 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

The Collaborative Care Model (CoCM) is an evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model includes:

1. care coordination
2. psychiatric consultation
3. measurement tracking

CoCM has been shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalizations and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

The need for the Collaborative Care Model is greater than ever. The mental health of people has dramatically worsened in the wake of the COVID pandemic. Adults saw an increase in rates of

depression from 6% to 25% from 2019 to 2021.[i1] Emergency department visits for potential suicidality for youth aged 12-17 increased 39% from 2019 to 2021.[2] The United States and Maryland are experiencing a mental health crisis, and this is especially true of youth.

While there is increasing need for youth mental health treatment, there are significant barriers to getting that treatment:

- There is a tremendous shortage of child and adolescent psychiatrists. Currently there are some 7,000 practicing child and adolescent psychiatrists, and it is estimated that the nation requires 30,000 to adequately meet the needs of children and adolescents.
- There is stigma associated with seeking out mental health services. Families of youth can be reluctant to seek care in specialty mental health treatment settings.
- There is mistrust of psychiatric practitioners.
- There are logistical barriers to seeking out specialty care – more appointments can mean more lost time from work and more costs.

For these reasons, less than half of pediatric patients referred for off-site specialty mental health services from primary care ever see a specialist within the following six months. Providing mental health care in a primary care setting is the solution to these barriers.

Indeed, currently, children and adolescents who do receive mental health services are usually cared for in primary care settings**. More than one-half of pediatric primary care visits address mental health problems, and pediatricians write 85% of psychotropic medication prescriptions for youth.[3]**

Yet mental health conditions in youth can be difficult to diagnose and prescribed treatment can frequently be less than successful. Pediatricians report challenges to providing quality mental health care:

- Lack of mental health training
- Insufficient time
- Lack of knowledge about community mental health resources
- Inadequate reimbursement

The CoCM, by pairing a primary care provider with a care coordinator, providing psychiatric consultation, measuring progress, and ensuring adequate reimbursement solves these concerns.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. **For these reasons, Maryland Coalition of Families urges this committee to pass HB 48.**

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[1] Centers for Disease Control and Prevention, National Center for Health Statistics (November 2022). Anxiety and Depression.

[2] Centers for Disease Control and Prevention (June 2021). Emergency Department Visits for Suspected Suicide Attempts among Persons Aged 12-25 Years Before and During the COVID-19 Pandemic – United States, January 2019-May 2021.

[3] Goodwin, R. etal, "Prescriptions of Psychotropic Medications to Youth Office-Based Practice, American Psychiatric Association (2001)

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
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HB 48_PJC_FAVORABLE_HGO.pdf
Uploaded by: Ashley Black
Position: FAV

Ashley Black, Staff Attorney
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HB 48
Maryland Medical Assistance Program – Collaborative Care Model Services Implementation and Reimbursement Expansion
Hearing of The House Health & Government Operations Committee
February 7, 2023
3:00 PM

SUPPORT

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health and Benefits Equity Project advocates to protect and expand access to healthcare and safety net services for Marylanders struggling to make ends meet. We support policies and practices that are designed to eliminate economic and racial inequities and enable every Marylander to attain their highest level of health. **PJC strongly supports HB 48**, which would require the Maryland Department of Health to expand access to and provide reimbursement for services provided in accordance with the Collaborative Care Model under the Maryland Medical Assistance Program (Medicaid).

The Collaborative Care Model is an evidence-based and patient-centered care model that integrates both primary care and behavioral health care. This team-based approach recognizes that most individuals with behavioral health conditions ranging from mild to moderate initiate their care in primary care settings. Through this model, individuals with behavioral health conditions receive care coordination and management, consistent treatment and care monitoring, behavioral health case review and consultations. Adopting the Collaborative Care Model would allow Maryland to serve individuals with behavioral health conditions in the community, thus reducing unnecessary hospitalizations and preserving scarce resources in higher intensity levels of care.

We thank the Maryland General Assembly for passing HB 1682/SB 835 (Chapters 683 and 684 of the Acts of 2018) which established the Collaborative Care Model Pilot Program in primary care settings. In the 2021 Joint Chairmen's Report on the Collaborative Care Pilot, MDH reported that more than 65% of Collaborative Care Model participants experienced clinically significant improvements in their anxiety and depression symptoms, demonstrating that this model can improve health outcomes of Marylanders with behavioral health conditions.[1]

[1] Maryland Department of Health, *2021 Joint Chairmen's Report – Collaborative Care Pilot Updates* (January 21, 2022), https://health.maryland.gov/mmcp/Documents/JCRs/2021/collaborativecarepilotJCRfinal11-21.pdf.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

We urge the State of Maryland to make the Collaborative Care Model a permanent feature of Maryland's Medicaid Program. HB 48 would positively impact the wellbeing and health of PJC's low-income clients, many of whom are eligible for Medicaid coverage, by providing a means for healthcare consumers to effectively access behavioral health care and primary care simultaneously.

For these reasons, the Public Justice Center urges the committee to issue a **FAVORABLE** report for **HB 48** so Maryland can join the more than 20 other states that are delivering necessary primary care and behavioral health care through the Collaborative Care Model. If you have any questions about this testimony, please contact Ashley Black at 410-625-9409 ext. 224 or blacka@publicjustice.org.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

HB0048 Collaborative Care Shepherd's Table. final.
Uploaded by: Brenna Olson
Position: FAV

House Bill 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

House Health and Government Operations Committee

February 7, 2023

TESTIMONY IN SUPPORT

Shepherd's Table is a social services organization that provides hot, nutritious meals, a free eye clinic, clothing, and other social services primarily to the unhoused community in Montgomery County, District 20. Many of our clients have experienced the trauma of unstable housing or food insecurity. They rarely have access to the necessary behavioral health care to assist them through such a difficult stage of life. Overcoming homelessness and hunger becomes even more complicated when it is exacerbated by behavioral health challenges, just as it is with physical health challenges. Shepherd's Table submits this testimony in support of HB 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion. HB 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, where most people with mild to moderate behavioral health conditions seek care first. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mainly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states providing CoCM broadly to their Medicaid recipients.

Receiving quality behavioral healthcare would make it easier for some individuals to get out of homelessness and even help prevent it. Ensuring that Medicaid recipients have access to the same healthcare that commercial patients do is essential for health equity. Behavioral healthcare IS healthcare, and everyone deserves quality care. This bill will improve behavioral health outcomes, save money, and keep people out of a crisis that could become detrimental to their housing situation. For these reasons, Shepherd's Table urges this committee to pass HB 48.

MC Federtation of Families Testimony Support HB 48
Uploaded by: Celia Serkin
Position: FAV

Montgomery County Federation of Families for Children's Mental Health, Inc.
Colesville Professional Center
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House Bill 48 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion
Testimony
House Health and Government Operations Committee
February 7, 2023
Position: Support

My name is Celia Serkin. I am Executive Director of the Montgomery County Federation of Families for Children's Mental Health, Inc., a family support organization providing family peer services, family navigation, group support, education, and advocacy for parents and other primary caregivers who have children, youth, and/or young adults with behavioral health challenges (mental health, substance use or co-occurring disorders). We serve families from diverse cultural, racial, ethnic, social-economic, and religious backgrounds. The organization is run by parents who have raised children with behavioral health challenges. I have two children, now adults, who have behavioral health challenges.

The Montgomery County Federation of Families for Children's Mental Health, Inc., is pleased to support House Bill 48 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion. HB 48 will repeal the Collaborative Care Pilot Program and require the Maryland Department of Health to expand access to and provide reimbursement for services provided in accordance with the Collaborative Care Model under the Maryland Medical Assistance Program.

HB 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM). CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

Montgomery County Federation of Families for Children's Mental Health, Inc. supports HB 48 because it will allow more children, youth, and young adults with behavioral health challenges to access mental health and

substance use treatment in primary care settings by eliminating barriers to care. As a family support organization, we have witnessed a heartbreaking surge in youth suicides and overdoses. The need for mental health and substance use treatment continues to increase. However, the stigma around mental health and substance use disorders and seeking help remains prevalent. This stigma can prevent families from seeking treatment. Many families would be open to receiving behavioral health treatment in primary care settings because this would be less stigmatizing.

CoCM promotes behavioral health equity. There are significant health and healthcare disparities among Black and Hispanic groups compared with Caucasian counterpart. CoCM can utilize the psychiatrist as a consultant whose time is not constrained by a burgeoning caseload, which will allow more patients to receive evidence-based treatment. At the same time, this will build the psychiatric competence of primary care providers over time. CoCM will permit psychiatry to be more equitably distributed so more individuals can be reached, including those in underserved and inappropriately served communities. CoCM will increase access to behavioral health treatment by offering (1) Care coordination and management; (2) Regular, proactive outcome monitoring and treatment for outcome targets using standardized outcome measurement rating scales and electronic tools, such as patient tracking; and (3) Regular systematic psychiatric and substance use disorder caseload reviews and consultation with a psychiatrist, an addiction medicine specialist, or any other behavioral health medicine specialist as allowed under federal regulations governing the model.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. For these reasons, the Montgomery County Federation of Families for Children's Mental Health, Inc. urges this committee to pass HB 48.

HB0048 Collaborative Care Model.pdf
Uploaded by: Dan Martin
Position: FAV

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House Bill 48 Maryland Medical Assistance Program –
Collaborative Care Model Services – Implementation and Reimbursement Expansion
House Health and Government Operations Committee
February 7, 2023
TESTIMONY IN SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of House Bill 48.

HB 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by providing them with access to the proven Collaborative Care Model (CoCM).

Most individuals will never seek or receive behavioral health treatment from a specialty provider. Instead, most people with mild to moderate depression and anxiety first seek to address these concerns with their primary care provider, a situation that is increasingly common given an ongoing and persistent behavioral health workforce shortage.

Unfortunately, behavioral health treatment delivered in primary care settings is often suboptimal, with individuals poorly diagnosed and treated, or not identified at all. National data indicates that only 25 percent of individuals receiving mental health treatment in the primary care setting receive quality care, resulting in high overall costs and poor health outcomes.

The Collaborative Care Model can help. CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings. Core elements include the use of standardized outcomes measures, care coordination and management, and the availability of behavioral health specialists for phone-based consultation to the primary care office.

The model has been validated in over 90 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care. As an example, Texas in 2021 passed a bill requiring statewide Medicaid coverage for CoCM, and the Texas HHS/Medicaid department determined, using implementation data from Massachusetts, that providing Medicaid coverage for CoCM would have "no significant fiscal implication to the state" because "the cost of providing collaborative care management services will be mostly offset by decreased costs related to reduced hospitalizations and utilization of other services."

For more information, contact Dan Martin at (410) 978-8865

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model, and an ongoing CoCM pilot in the Maryland Medicaid program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly across their Medicaid programs. Maryland Medicaid recipients deserve access to the same proven service currently available to those with commercial insurance or Medicare.

This bill will address inequities in the delivery of behavioral health care, improve behavioral health outcomes, save money, and keep people out of crisis. **For these reasons, MHAMD supports HB 48 and urges a favorable report.**

HB 48_Maryland Medicaid Colab Care Expansion_BHSB_
Uploaded by: Dan Rabbitt
Position: FAV

Behavioral Health System Baltimore

February 7, 2023

House Health and Government Operations Committee
TESTIMONY IN SUPPORT
HB 48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment, crisis response, and recovery for individuals, families, and communities. Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 78,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.

Behavioral Health System Baltimore strongly supports HB48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion. HB48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is an evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular monitoring and treatment; and (3) systematic behavioral health caseload reviews and consultation. This combination of behavioral health support and consultation in primary care settings is effective. Over 80 randomized controlled trials have shown CoCM to be effective at improving health outcomes and lowering costs through a reduction in unnecessary hospitalization and higher intensity levels of care.

Integrating behavioral health care management into primary care would be beneficial to the residents of Baltimore City and its public behavioral health system. The impact of pandemic related isolation and disruption continues to manifest in higher rates of anxiety and depression, especially among young people. Over 2/3 of people seeking care for depression and other moderate mental health challenges go first to their primary care physician. Better support for primary care-behavioral health integration will address behavioral health needs before they become crises.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering care through this model. Maryland Medicaid also has an ongoing CoCM pilot program. The Medicaid pilot has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to move beyond the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. **BHSB urges the House Health and Government Operations to pass HB48.**

For more information, please contact BHSB Policy Director Dan Rabbitt at 443-401-6142

collaborativecarepilotJCRfinal11-21.pdf
Uploaded by: Heather Bagnall
Position: FAV

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

January 21, 2022

The Honorable Guy Guzzone
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair, House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2021 Joint Chairmen's Report (p. 113-114) – Collaborative Care Pilot Updates

Dear Chair Guzzone and Chair McIntosh:

In keeping with the requirements of the 2021 Joint Chairmen's Report (p. 113-114), the Maryland Department of Health respectfully submits the report on the Collaborative Care Pilot Updates.

If you have any questions about this report, please contact Heather Shek, Director, Office of Governmental Affairs, at heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

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2021 Joint Chairmen's Report

p. 113 - 114

Collaborative Care Pilot Updates

Table of Contents

Executive Summary

Pursuant to Chapters 683 and 684 of the Acts of 2018 (HB 1682/SB 835), the Maryland Department of Health (MDH) was required to establish and implement the Collaborative Care Model (CoCM) Pilot Program in primary care settings in which health care services are provided to Medical Assistance Program participants enrolled in HealthChoice. The legislation required MDH to administer the CoCM Pilot Program and to select up to three pilot sites with certain characteristics to participate. The CoCM pilot is part of MDH's larger strategy to better integrate care for Medicaid participants through recommendations being developed by the Behavioral Health System of Care Integration and Optimization Workgroup. MDH selected three sites to participate in the CoCM Pilot Program via a competitive application process. Funding included up to $225,000 during the first fiscal year ((FY) 2020) for infrastructure, $325,000 for services rendered during the second half of fiscal year FY 2020 (January 1, 2020 through June 30, 2020), and up to $550,000 annually for services rendered for FY 2021, FY 2022, and FY 2023 (July 1, 2020 through June 30, 2023).

Due to the COVID-19 pandemic, enrollment in the CoCM Pilot Program has been more limited than initially projected due to declines in utilization of primary care services. However, preliminary results suggest that the CoCM Pilot Program has improved clinical outcomes. MDH estimates implementing the model statewide would have a fiscal impact of $18.8 million to $32.4 million total funds annually. MDH recommends continuing the pilot program until the end of FY 2023 and conducting a full evaluation at that time. MDH will also continue to work with stakeholders, including the Behavioral Health System of Care Integration and Optimization Workgroup, to find innovative ways to improve behavioral health outcomes for participants.

Background

Pursuant to the Joint Chairmen's Report of 2021 (page 113-114), MDH respectfully submits this report on the current status of the CoCM Pilot Program, with a specific focus on initial data and whether this data warrants a statewide implementation.

The Collaborative Care Model (CoCM)

Pursuant to Chapters 683 and 684 of the Acts of 2018 (HB 1682/SB 835), the Maryland Department of Health (MDH) was required to establish and implement the Collaborative Care Model (CoCM) Pilot Program in primary care settings in which health care services are provided to Medical Assistance Program participants enrolled in HealthChoice.

CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. A collaborative care team is responsible for delivery and management of patient-centered care. Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders for the patient. This in turn encourages patients to seek access to the evidence-based behavioral health services available in their regular primary care clinics resulting in improved patient outcomes. Patients are screened through a standardized questionnaire, such as the PHQ-9 for depression or the GAD-7 for anxiety.

The CoCM incorporates a team of three providers: (1) a primary care provider (PCP), (2) a behavioral health (BH) care manager, and (3) a psychiatric consultant. In Maryland's Medicaid program, a physician, nurse practitioner, nurse midwife, or physician assistant may serve as a PCP. The BH care manager possesses formal education or specialized training in behavioral health. The role is typically filled by a nurse, clinical social worker, or psychologist who is trained to provide coordination and intervention who works under the oversight and direction of the PCP. Together, the BH care manager and the PCP form the primary care team. The psychiatric consultant is typically either a licensed psychiatrist or psychiatric nurse practitioner. For purposes of the CoCM Pilot Program, an addiction medicine specialist or any other behavioral health medicine specialist as allowed under federal regulations governing the model may also serve as a consultant.

Behavioral Health System of Care Integration and Optimization Workgroup

The CoCM pilot is part of MDH's larger strategy to better integrate care for Medicaid participants through the Behavioral Health System of Care Integration and Optimization Workgroup. In response to legislation that was introduced—but did not pass—during the 2019 legislative session, the chairs of the Senate Finance and Health and Government Operations Committees requested MDH to convene stakeholders and make recommendations on how the state should provide, administer, and finance Medicaid behavioral health services. Formed in 2019, paused during calendar year 2020 due to COVID-19, and reconvened in the fall of 2021, the Workgroup aims to better serve Medicaid participants by developing a System of Care that addresses the needs to individuals by aligning the roles of Medicaid, the Behavioral Health Administration (BHA), the nine managed care organizations (MCOs), the administrative services organization (ASO) that administers behavioral health benefits in Medicaid, and local systems management.

The key themes for potential initiatives under discussion by the Workgroup are:

- Value-based payment, measure-based care, quality measurement, and provider management;
- Case management, care coordination, and clearly defining roles within the system;
- Integration of care; and
- Data sharing.

The Workgroup is currently considering and vetting a variety of programs and projects with the potential to forward progress on the themes outlined above. Expansion of CoCM is one proposal under consideration, and Workgroup members will review the data presented in this Joint Chairmen's Report. Other initiatives under discussion include, but are not limited to: establishing standards for behavioral health provider networks and quality; developing a formal structure for addressing high utilizers of services; identifying barriers to billing for co-occurring disorders; reviewing supports needed by MCOs to increase uptake of screening;brief intervention; referral to treatment (SBIRT) by providers; and enhancements to improve behavioral health data sharing with the MCOs. Discussion by the workgroup regarding selection of an initiative to move forward are ongoing.

CoCM in Maryland Medicaid

In 2016, MDH submitted a Joint Chairmen's Report on CoCM and whether it could be implemented in Maryland.[1] The report concluded that while CoCM was a clinically-effective model of care, it would require a substantial budget initiative. MDH proposed a one year pilot program to test the model. In 2017, MDH submitted an update to this report, emphasizing that CoCM could play an important role in behavioral health integration.[2] Based on an Institute for Clinical and Economic Review (ICER) estimate and a low prevalence rate of depression (defined as 3%), MDH estimated that implementing CoCM for 200,000 participants would require a $3 per member per month (PMPM) payment and cost $7.2 million ($4.3 million federal funds and $2.9 million state general funds). MDH again proposed doing a limited pilot program to test the model.

During the 2018 session, the Maryland General Assembly passed HB 1682/SB 835, which required MDH to establish a limited CoCM Pilot Program at up to three sites, one of which was required to be in a rural area. MDH was also required to apply for an 1115 waiver amendment with the Centers for Medicare and Medicaid (CMS) in order to implement the pilot program. MDH received $550,000 per fiscal year for the pilot program.

MDH applied for an 1115 waiver amendment in June 2019, and CMS approved the waiver in April 2020, with an implementation date of July 1, 2020.

MDH issued a request for applications for the CoCM Pilot Program in Spring 2019, with letters of intent due in April 2019 and applications due in May 2019. Funding included up to $225,000 in FY 2020 for infrastructure costs as well as $325,000 for services rendered during the second half of FY 2020 (January 1, 2020 through June 30, 2020), and up to $550,000 annually for services rendered for FY 2021, FY 2022, and FY 2023 (July 1, 2020 through June 30, 2023). Sites were selected in June 2019 and infrastructure awards began in July 2019. Sites began phasing in enrollment in April 2020 and federal match under the 1115 waiver was available beginning July 2020.

The CoCM Pilot Sites

MDH selected sites through a competitive process that scored applications based on the quality and scope of the application, including staffing, workflow, target populations, as well as previous experience with CoCM. Privia Health's three separate applications had the highest scores. Privia submitted separate applications for three distinct practice settings:

[1] 2016 Joint Chairmen's Report (p. 78) Opportunities to Adopt the Collaborative Care Model in the HealthChoice Program. http://dlslibrary.state.md.us/publications/JCR/2016/2016_78a.pdf
[2] 2017 Joint Chairmen's Report (p. 87) Report on the Approach for the Integration of Behavioral and Somatic Services. http://dlslibrary.state.md.us/publications/JCR/2017/2017_87,89.pdf

1. Privia Obstetric/Gynecology Practice – expected to enroll a population of 45 pregnant and postpartum individuals into CoCM per year who screen positive for depression.
2. Privia Rural Practice – serving a population with both mental health and substance use disorders, and deploying telehealth to bridge the resource gap that often exists in rural communities. Privia expected to treat 25 CoCM participants at their rural site annually.
3. Privia Urban Practice – serving a population of non-English speakers, specifically Spanish and Mandarin populations. Privia Health proposed building up to enrollment of 185 participants into CoCM across their urban sites annually.

The sites are located throughout the state. Privia's rural site is in Waldorf, MD; their urban sites are located in Frederick, and Silver Spring; the obstetric/gynecology site is based in Rockville, MD.

Reporting Requirements

MDH requires selected CoCM Pilot Sites to report on the certain metrics in order to evaluate the effectiveness of the Pilot Program. These include enrollment metrics, screening metrics, and duration of treatment metrics. For a detailed list of required measures, please see Appendix A.

Additionally, MDH evaluated the impact of the CoCM Pilot Program on the number of and outcomes for individuals who:

1. Were not diagnosed as having a behavioral health condition before receiving treatment through the pilot program;
2. Were not diagnosed as having a behavioral health condition before being referred to and treated by a specialty behavioral health provider;
3. Received behavioral health services in a primary care setting before receiving treatment through the CoCM Pilot Program; and
4. Received specialty behavioral health care services before being identified as eligible to receive treatment through the CoCM Pilot Program.

Preliminary Results

While the CoCM Pilot Program is still ongoing, MDH has begun to analyze preliminary data. Due to the COVID-19 pandemic, the pilot sites were not able to enroll as many participants as they anticipated.

Overall, 399 unique participants have been identified as eligible for CoCM. Of those, 129 participants (31 percent) have completed treatment. 168 participants never enrolled in the program, meaning they were eligible for CoCM after a preliminary screening and received outreach attempts, but never completed enrollment.

Table 1: CoCM Pilot Program Status Categories and the Number and Percent of Participants in Each Category as of March 2021

Program Status	Unique #	Unique %	Total #	Total %
Active	78	20%	78	19%
Completed	129	32%	129	31%
Pending	24	6%	25	6%
Not Enrolled	168	42%	186	45%
Total	**399**	**100%**	**418**	**100%**

For participants who were considered active in CoCM, the average point decrease in PHQ-9 score ranged from a 1.1 to 2.6. For the GAD-7, the average point decrease ranged from 0.04 to 1.3. Decreasing scores for both tests indicate improvements in participants' depression and anxiety.

Table 2: Mean Change in Test Scores for Active Participants by Quarter

	Test	Participants	Mean Change
FY 2021 Q2	PHQ-9	38	-2.6
	GAD-7	32	-0.8
FY 2021 Q3	PHQ-9	58	-2.3
	GAD-7	52	-1.3
FY 2021 Q4	PHQ-9	49	-1.1
	GAD-7	46	-0.04

For patients that have been enrolled for more than 70 days, more than 65 percent have had clinically significant improvement, meaning their baseline score dropped more than 50 percent or their score dropped below the level of eligibility for CoCM. In the most recent quarter (FY 2021 Q4), 29 percent of participants achieved remission criteria.

Current Fiscal Impact in Maryland

MDH adopted Medicare's payment structure for the CoCM Pilot Program. The fee schedule is as follows:

Table 3: CoCM Billing Codes

Codes	Description	Primary Care Rate Setting
99492	First 70 minutes in the first calendar month or behavioral health care manager activities	$161.28
99493	First 60 minutes in a subsequent month for behavioral health care manager activities	$128.88
99494	Each additional 30 minutes in a calendar month of behavioral health care manager activities	$66.60

As of June 30, 2021, MDH, through the pilot sites, has spent $378,559.61 on the CoCM Pilot Program. $172,012.44 was spent on infrastructure during the first year (FY 2020) and $206,547.17 was spent on services through FY 2020-21.

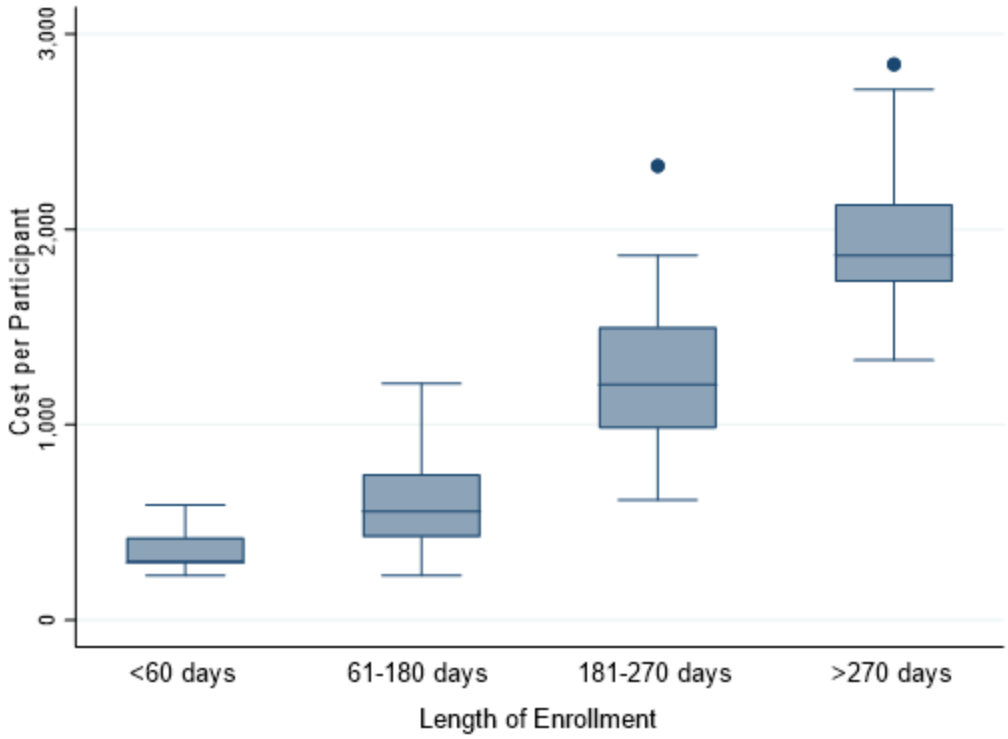
For active program participants, the average cost to the state as of March 31, 2021 was $996.10 per person with an average length of enrollment of 203 days. The median cost and enrollment are $752.04 and 175 days respectively. Participants who have either successfully completed the CoCM Pilot Program or been referred to the behavioral health ASO have an average cost of $645.72 and an average length of enrollment of 91 days. The median cost and length of enrollment is $552.24 and 73 days respectively. Overall, average charges for active and completed participants are $775.30, with an average length of enrollment of 134 days. The median cost and length of enrollment are $556.56 and 112 days respectively.

Table 4: Length of Enrollment and Cost of Active and Complete Participants in CoCM as of March 31, 2021

	Mean	Median
Active Participants Only (n = 78)		
Costs	$996.10	$752.04
Length of Enrollment (Days)	203	175
Completed Participants Only (n = 129)		
Costs	$645.72	$552.24
Length of Enrollment (Days)	91	73
Active & Completed Participants (n = 207)		
Costs	$775.30	$556.56
Length of Enrollment (Days)	134	112

A higher average cost per participant was associated with a longer length of enrollment. A simple linear regression model of costs on length of enrollment estimated that, on average, one extra day of enrollment increased costs by $5.42. For participants enrolled for less than 2 months (60 days), the average cost was $338.35. These average costs increased based on length of enrollment, with participants who have been enrolled for longer than 9 months (greater than 270 days) having an average cost of $1,967.79.

Figure 1: Cost by Length of Enrollment Category for Participants who are Active in or Have Completed the Collaborative Care Model Pilot Program, April 2020 to March 2021



Statewide Expansion Costs and Considerations

Other State Programs

As of May 2021, 19 other state Medicaid programs have started reimbursing for CoCM codes (Arizona, California, Illinois, Iowa, Kentucky, Massachusetts, Maryland, Michigan, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, Vermont, and Washington). Reimbursement for the CoCM codes varies from state to state with New Hampshire having the lowest rates and Montana having the highest for each code.[3]

[3] "Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care." California HealthCare Foundation, May 2021. https://www.chcf.org/publication/cracking-codes-state-medicaid-approaches-reimbursing-psychiatric-collaborative-care/

Table 5: CoCM Reimbursement Rates in Medicaid Programs

Codes	Medicaid-Only Ranges	Medicaid Mean	Medicare Rate[4]
99492	$56 to $176	$114	$161.28
99493	$51 to $140	$94	$128.88
99494	$27 to $82	$49	$66.60

Statewide Expansion Estimated Fiscal Impact

In the 2017 CoCM JCR, MDH estimated that CoCM would cost approximately $3.00 per member per month (PMPM) based on a 3% prevalence rate of depression.[5] MDH noted that if the prevalence of depression were higher or increased, that the costs associated with CoCM would increase as well.[6] Assuming a $3 PMPM cost, covering the HealthChoice population of 1.4 million participants would have an estimated annual fiscal impact of $50.4M.

In calendar year (CY) 2020, approximately 2.9 percent of HealthChoice participants received behavioral health services from an MCO but did not access services through the ASO, suggesting that a 3% prevalence estimate remains accurate. This prevalence rate has remained relatively stable year over year back to CY 2017.

[4] Please note that MDH uses the Medicare rate.
[5] Tice, Jeffrey A., et al.. Integrating Behavioral Health into Primary Care. Institute for Clinical and Economic Review. June 2, 2015. Page ES6. http://icerorg.wpengine.com/wp-content/uploads/2020/10/BHI_Final_Report_060215.pdf
[6] Report on the Approach for the Integration of Behavioral and Somatic Services and Report on Collaborative Care Revisited. 2017. https://health.maryland.gov/mmcp/Documents/JCRs/2017/BHIJCRfinal1-18.pdf.

Table 6: Number of HealthChoice Participants with Any Behavioral Health Services Covered by the MCO with no ASO Service, CY 2020

MCO	Total Participants	Number	Percentage
Aetna	47,685	1,082	2.3%
Amerigroup	313,335	6,660	2.1%
Jai Medical Systems	30,717	676	2.2%
Kaiser Permanente	99,170	2,100	2.1%
Maryland Physicians Care	239,685	9,591	4.0%
Medstar Family Choice	105,423	3,379	3.2%
Priority Partners	340,133	10,666	3.1%
United Healthcare	166,470	5,311	3.2%
University of Maryland Health Partners[7]	56,517	1,539	2.7%
Total	**1,399,135**	**41,004**	**2.9%**

As a comparison to the ICER estimate, MDH utilized the preliminary pilot experience to develop an alternative fiscal estimate as described below. MDH assumes that 2.9 percent of all HealthChoice participants would be eligible for CoCM, consistent with the percent that received behavioral health services through the MCOs in CY 2020. MDH also assumes that approximately 42 percent of participants will not be interested in CoCM (consistent with the percent of unique participants that were not enrolled at the CoCM pilot sites) and that 58 percent would be interested in enrolling. Assuming that the cost per participant is consistent with the CoCM Pilot Program data and averages at $775.30, the total fiscal impact of CoCM would be approximately $18.4 million annually. If all eligible HealthChoice participants enrolled in CoCM, the fiscal impact could be up to $31.8 million per year.

Expanding coverage to also include the fee-for-service (FFS) population would increase the estimated fiscal impact. In CY 2020, 68,090 FFS participants did not have Medicare coverage.[8]

[7] Please note that University of Maryland Health Partners became Carefirst in October 2020.

[8] Please note that Medicare participants are already eligible to receive CoCM services through their Medicare plans. Therefore, any CoCM services received by those participants would be paid through Medicare and not the responsibility of MDH.

Approximately 1.2 percent, or 841 of these FFS participants, had a claim with an associated behavioral health diagnosis and received no services through the ASO. Assuming (consistent with the MCO estimate), a per person cost of $775.30 a 58 percent uptake rate, it would cost approximately $378 thousand to cover the FFS population. Because these funds would be eligible for a 50 percent federal match, the state cost would be $189 thousand; the federal cost would also be $189 thousand. If all 841 participants enrolled in CoCM, it would cost $652 thousand.

Covering both the FFS population and the MCO population could cost from $18.8 million to $32.4 million.

MDH notes that these estimates should be interpreted with caution. Actual uptake and utilization of the program may be higher. Preliminary data from the CoCM pilot program is limited to one year with a relatively small cohort. Additionally, uptake was also limited due to the COVID-19 pandemic; utilization during this time period may not be indicative of normalized trends. Finally, participants who were receiving specialty BH services from the ASO are not eligible for this pilot program. If participants were allowed to receive BH services through the ASO and CoCM simultaneously, utilization rates and costs would increase, potentially up to $114.5 million to cover the 18.2 percent of the HealthChoice population with a mental health or substance use disorder diagnosis.

Other CoCM Initiatives in Maryland

Behavioral Health Integration in the Maryland Primary Care Program

The Maryland Primary Care Program (MDPCP) was implemented in 2019. The MDPCP program provides payments directly for Medicare beneficiaries, while also focusing on total practice transformation that benefits patients across all payers. All 525 primary care practices participating in MDPCP in 2021 are required to integrate behavioral health into their practices. MDPCP provides funding to facilitate the hiring of social workers, CHWs, and care managers in the practices. These staff work with patients to ensure they receive the care and services they need to stay healthy. In addition, over 300 MDPCP practices have implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify and appropriately refer patients with substance use disorders before the substance use creates a crisis. As of 2021 MDPCP practices also receive an incentive payment to improve performance on screening patients for depression and establishing a follow up plan. Results from the performance measure will not be available until Fall 2022.

In the Collaborative Care Model, practices utilize proactive, relationship-based care management to establish a closed-loop referral system for patients whose behavioral health needs exceed the scope of primary care. Across all MDPCP practices, 100% reported developing a strategy for integrating behavioral health into their practice workflows by the end of the Q3 2021 via the Care

Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs. Of these, 39% of practices reported using the Care Management or Collaborative Care Model either exclusively or in conjunction with other methods to integrate behavioral health into their practice. Furthermore, as of the end of 2020, 69 MDPCP practices had referred patients to Mindoula, a health management company that connects patients to mental health providers who administer "Collaborative Care" treatment. As of October 2021, Mindoula reports over 90 practices are actively partnered and referring patients.

Conclusions and Next Steps

Preliminary results of the CoCM Pilot Program suggest that receipt of CoCM services is associated with clinical improvement. Given that data from the pilot is limited and enrollment has been impacted by COVID-19, MDH recommends continuing the pilot program to monitor outcomes.

Following completion of the CoCM Pilot Program in FY23, MDH will conduct a more comprehensive evaluation to assess whether it achieved the goal of not only improving clinical outcomes and access to care, but also controlled costs. MDH will continue to work with stakeholders, including the Behavioral Health System of Care Integration and Optimization Workgroup, to find and implement innovative ways to improve behavioral health outcomes for participants.

Appendix A: Detailed Reporting Requirements

1. **Enrollment** – The total number of Medicaid patients enrolled in Collaborative Care treatment during this month.
2. **Newly enrolled** – Among enrolled patients, the number of patients who were diagnosed with Depression or Anxiety or other targeted behavioral health diagnosis and enrolled in treatment by the BH care manager this month.
3. **Average Duration of Treatment** – Average number of weeks between initial assessment to date of discharge from Collaborative Care.
4. **Monthly Contact** – Number (#) and proportion (%) of patients receiving active treatment in CoCM defined by those patients who have had at a clinical contact this month:
    a. Numerator: Patients that have had at least one clinical contact this month.
    b. Denominator: Total number of patients enrolled during this month.
    c. **Note:** A "clinical contact" is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement as long as treatment is delivered.
5. **Clinical Contacts by Phone** – Number (#) and proportion (%) of telephonic touches for patients enrolled in treatment over the total number of touches that month. See note above regarding definition of "clinical contact".
6. **Improvement Rate** – Number (#) and proportion (%)of patients enrolled in treatment for 70 days or greater who demonstrated clinically significant improvement defined as:
    a. A 50% reduction from baseline PHQ-9, or
    b. A drop from baseline PHQ-9 to less than 10
        i. Numerator: Patients that have met Improvement criteria.
        ii. Denominator: All patients enrolled in Collaborative Care for 70 days or more.
7. **Remission Rate** – Number (#) and proportion (%) of patients enrolled in treatment for any length of time who have achieved remission criteria (PHQ-9 below 5) during this month:
    a. Numerator: Patients whose most recent PHQ-9 is below 5.
    b. Denominator: Total number patients enrolled during this month.
8. **Psychiatric Consultation or Change in Treatment Rate** – Among those enrolled in treatment for 70 days or more who did not improve, number (#) and proportion (%) who whose case was reviewed by the Consulting Psychiatrist with treatment recommendations provided to the Primary Care Provider or Depression Care Manager OR had a documented change made to their treatment plan this month:
    a. Numerator: Patients who have had their case reviewed by the Consulting Psychiatrist OR had a change documented in their treatment plan this month.

    b. Denominator: Patients that have been enrolled for 70 days omdr more who have not met clinical improvement criteria this month.
9. **Depression Screening Rate** – Number (#) and proportion (%) of all unique adult patients seen during the reporting period who received their annual PHQ-2 or PHQ-9 screening:
    a. Numerator: Patients that received a PHQ-2 or 9 during this visit, or have been screened in the last year.
    b. Denominator: All patients seen in the practice for any reason that month
10. **Depression Screening Yield** – Number (#) and proportion (%) of all unique adult patients who scored a 10 or greater on their initial PHQ-9 during the reporting period:
    a. Numerator: Patients that scored a 10 or higher on their initial PHQ-9.
    b. Denominator: All patients screened with a PHQ-9 during that month.

HB0048_Sponsor_FAV.pdf
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Position: FAV

HEATHER BAGNALL
Legislative District 33C
Anne Arundel County

Health and Government Operations Committee
Subcommittees
Health Occupations and Long-Term Care
Public Health and Minority Health Disparities

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February 7, 2022

HB0048 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

Good afternoon Madam Chair, Madam Vice Chair, and members of the Health and Government Operations Committee. Thank you for the opportunity to present to you House Bill 48.

You have before you today a timely and evidence-informed piece of legislation to refine Maryland's behavioral health system to meet the growing demand for mental health services here in Maryland. Although our state has made significant advancements in how we treat mental health, this bill provides us with an opportunity to turn a good mental health system into a great one through the expansion of an innovative healthcare model, outlined below.

House Bill 48 expands the Collaborative Care Model, a patient-centered, evidence-based approached for integrating physical and behavioral health services in primary care settings. Under this model, emphasis is placed on coordination and management of care across different fields, regular monitoring and treatment of patients, and systemic caseload reviews and consultation for patients who do not show improvement.[1] Following these guidelines creates a framework for effective preventative care, reducing hospitalizations and cost-of-care across the state.

This is not the first time the Collaborative Care Model has been utilized in Maryland: in 2018, the Maryland General Assembly passed a bill to establish a Collaborative Care Model Pilot Program to determine whether such a program should be implemented state-wide. This pilot program produced dramatic positive results. Immediately after the model's implementation, psychiatric hospitalization for those suffering depression, PTSD, anxiety, and other mental health disorders fell dramatically,[2] and racial and ethnic minorities receiving care through the Collaborative Care model saw notable improvements in depression.[3] All of this was accomplished at a lower net cost of enrollment per patient when compared to current care practices.[4]

All-inclusive preventative care will be provided to patients, combining primary care and mental health treatment in a way that makes each more accessible. As a result, Marylanders will receive a full spectrum of care proactively and comprehensively, leading to improved long-term health outcomes.

[1] https://health.maryland.gov/mmcp/Documents/JCRs/2021/collaborativecarepilotJCRfinal11-21.pdf
[2] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0249007
[3] https://www.sciencedirect.com/science/article/pii/S0033318220300608?via%3Dihub
[4] See footnote 3

This bill is crucial if we want to be sure all Marylanders struggling with mental health and substance use disorder receive the assistance they need. This is an evidence-driven, cost-effective, and strategic model to bring Maryland's mental healthcare system into the 21st century.

I respectfully request a favorable report on House Bill 48.

HB 48 - Support _ Collaborative Care - HGO - Feb
Uploaded by: Henry Bogdan
Position: FAV

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February 7, 2023

Testimony on House Bill 48

Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

House Health and Government Operations Committee

Position: Favorable

Maryland Nonprofits is a statewide association of more than 1500 nonprofit organizations and institutions. We strongly urge you to support House Bill 48 – improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

House Bill 48 offers the opportunity to improve outcomes and save state resources, while addressing a mental health crisis worsened by the continuing pandemic. **For these reasons we urge a Favorable Report on HB 48.**

HB 48 - Maryland Medical Assistance Program - Coll

Uploaded by: Jake Whitaker

Position: FAV

Maryland
Hospital Association

February 7, 2023

To: The Honorable Joseline Peña-Melnyk, Chair, House Health & Government Operations Committee

Re: Letter of Support- House Bill 48 - Maryland Medical Assistance Program - Collaborative Care Model Services - Implementation and Reimbursement Expansion

Dear Chair Peña-Melnyk:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on House Bill 48. Maryland hospitals care for everyone who comes through their doors, but too often patients in crisis, particularly youth, visit hospital emergency departments due to a lack of behavioral health services in the community.

The Collaborative Care Model (CoCM) is a validated, patient-centered, evidence-based approach to integrate physical and behavioral health care in primary care settings—where most people with mild to moderate behavioral health conditions first seek, but frequently do not, receive behavioral health care services. CoCM resolves this issue by using a team-based approach in primary care settings to deliver:

- Care coordination and management
- Regular, systematic monitoring and treatment using a validated clinical rating scale
- Regular, systematic behavioral health caseload reviews and consultation for patients

As a result of the ongoing national health care provider shortage, including behavioral health professionals, Maryland patients frequently access behavioral health services for the first time when in crisis during visits to hospital emergency departments. When patients have access to these services in primary care settings, patients can get the help they need at the onset of behavioral health conditions and stay out of crisis. CoCM has been critical to maximize the number of patients that can be served by the limited number of behavioral health care professionals. Maryland hospitals are facing historic workforce shortages, and CoCM provides the necessary supports to ensure patients receive the best care.

Any sustainable solution will require a holistic approach like CoCM. This bill will improve the availability of behavioral health services, improve outcomes, keep people out of crisis, and decrease the number of unnecessary emergency department visits.

For these reasons, we request a ***favorable*** report on HB 48.

For more information, please contact:
Jake Whitaker, Director, Government Affairs
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Sheppard Pratt written testimony SB101 : HB48 Coll
Uploaded by: Jeffrey Grossi
Position: FAV

Sheppard Pratt

Written Testimony

Senate Finance Committee

House Health and Government Operations Committee

SB 101 / HB 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

January 30, 2023

Position: SUPPORT

Sheppard Pratt thanks the Maryland General Assembly for your longstanding leadership and support of mental and behavioral health providers in Maryland. This testimony outlines the Sheppard Pratt support of **SB 101 / HB 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion**. It is our hope that the Maryland General Assembly vote a favorable report on this legislation.

SB 101 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

At Sheppard Pratt, we know that the model will develop universal mental health screening, brief treatment, and psychiatric consultation for those who might otherwise never be identified as needing help.

We stood up a similar model in seven primary care settings. Patients trusted their primary care providers and agreed to meet with a behavioral health provider if referred to behavioral health consultants by their primary care providers. Treatment was often brief and both clinically and cost effective.

Jeffrey Grossi, JD, Chief of Government Relations | jgrossi@sheppardpratt.org | 410.371.3306

Sheppard Pratt

Early intervention for depression and substance abuse in a primary care setting can reduce more expensive medical co-morbidities, support whole families, and reduce absenteeism at work.

Clients who are screened in primary care sometimes don't recognize they are suffering from depression, and if they are aware that something is wrong, they frequently have not sought treatment from a specialty behavioral health program because of stigma. Primary care settings have significantly less stigma for those with mild to moderate symptoms.

Sheppard Pratt's partnership with the Greater Baltimore Medical Center (GBMC) has resulted in screening and treatment for patients in GBMC primary care offices. Patients with more serious or chronic mental health diagnoses are referred by the collaborative care teams in primary care practices to specialty mental health providers.

Mental Health America's national data[1] makes it clear that across the country over 56 percent of adults with mental illness receive no treatment. In Maryland 30 percent of adults with mental illness reported that they are not able to receive the treatment they need.

Expanding screening and brief treatment in primary care settings can help close the gap for those who need care, improve the skills of primary care providers, and make mental health care increasingly accessible in a safe and cost-effective model.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis.

Sheppard Pratt urges you to vote a favorable report on **SB 101 / HB 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion.**

About Sheppard Pratt

Sheppard Pratt is the nation's largest private, nonprofit provider of mental health, substance use, developmental disability, special education, and social services in the country. A nationwide resource, Sheppard Pratt provides services across a comprehensive continuum of care, spanning both hospital- and community-based resources. Since its founding in 1853, Sheppard Pratt has been innovating the field through research, best practice implementation, and a focus on improving the quality of mental health care on a global level. Sheppard Pratt has been consistently ranked as a top national psychiatric hospital by *U.S. News & World Report* for nearly 30 years.

[1] https://mhanational.org/issues/2022/mental-health-america-adult-data

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House Bill 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

House Health and Government Operations Committee

February 7, 2023

TESTIMONY IN SUPPORT

Voices of Hope, Inc. is a nonprofit community-based organization that serves individuals with substance use disorders in Cecil and Harford Counties. We provide harm reduction and SUD treatment navigation services, operate Recovery Community Centers and 2 recovery houses. We engage with people who use drugs and are experiencing traumatic events including wounds from injection drug use and homelessness. We believe that many severe health concerns could be addressed in primary care settings before reaching the level of needing crisis health care.

HB 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care. Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated “clinically significant improvement” in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

Voices of Hope, Inc. believes that this model will prevent crisis care and avoid deaths. This bill will improve behavioral health outcomes, save money, and keep people out of crisis**. For these reasons, Voices of Hope, Inc urges this committee to pass HB 48.**

Thank you,

Jennifer Tuerke
Executive Director

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224 E. Main St. Elkton, MD 21921

MABGH HB0048 Collaborative Care Testimony.pdf
Uploaded by: John Miller
Position: FAV

MidAtlantic
BUSINESS GROUP
ON HEALTH

House Bill 0048
Collaborative Care Implementation and Reimbursement
Health and Government Operations Committee
February 7, 2023
Position: SUPPORT

The MidAtlantic Business Group on Health is a coalition that helps companies achieve cost-effectively, high-quality healthcare for employees and dependents; collaborates with other community stakeholders; and represents the healthcare purchasers' voice. We appreciate this opportunity to present this testimony in support of House Bill 0048.

House Bill 0048 expands reimbursement from an existing Collaborative Care Model pilot program to be statewide in primary care settings that provide health care services to Program recipients.

Employers are very concerned with the difficulty that their employees and dependents face when seeking mental health support. Every day, company Human Resource officers share the frustration of employees seeking effective behavioral health care. We understand that most of these individuals receive this support from their primary care healthcare provider, especially given the difficulty they have getting appointments with behavioral health specialists.

However, primary care providers are not specially trained to diagnose and treat behavioral health, which means that care delivered in the primary care setting can be less than optimal. This results in additional anguish for employees and their children, and it also impacts overall healthcare costs. Studies show that patients with behavioral health conditions have MEDICAL/ SURGICAL costs that are 3-5 times higher than patients with no behavior health condition. The Collaborative Care Model can alleviate this problem, by supporting primary care clinicians in delivering behavioral health services.

The MidAtlantic Business Group on Health encourages all businesses to pay for Mental Health Collaborative Care. The weight of the Maryland Medical Assistance Program would speed adoption of the Collaborative Care Model, which will lower healthcare costs, but more importantly, ease the burden of behavioral health conditions for employees and their dependents.

For this reason, the MidAtlantic Business Group on Health supports House Bill 0048.

John Miller

MidAtlantic Business Group on Health
PO Box 0866 Greenbelt, Maryland 20768 Ph. (301) 552-5530
john.miller@mabgh.org

HB0048.pdf
Uploaded by: Jonathan Dayton
Position: FAV

Statement of Maryland Rural Health Association (MRHA)
To the House HGO Committee
Chair: Joseline A. Pena-Melnyk
January 30, 2023
House Bill 48: Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

POSITION: SUPPORT

Chair Pena-Melnyk, Vice Chair Kelly and members of the Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of House Bill 48, Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion.

MRHA believes that Medicaid reimbursement of behavioral health services via the collaborative care model services will greatly benefit Maryland residents. According to the National Alliance on Mental Illness, more than half the people in Maryland with mental illness did not receive any treatment.[i] .By requiring Medicaid reimbursement, more people in need of mental health services will have access through a collaborative care model. The collaborative care model has been continuously proven to improve quality of care, patient outcomes, and patient safety.[ii] No one should be denied such effective services.

Without Medicaid reimbursement, the approximately 1.5 million Marylanders enrolled in Medicaid will continue to be denied critical and effective mental health services. With this fact in mind, we urge you to support HB48.

Sincerely,

Jonathan Dayton, MS, NREMT, CNE, Executive Director

jdayton@mdruralhealth.org

hb48- CoCM expansion, HGO 2-7-'23.pdf
Uploaded by: Lee Hudson
Position: FAV

Delaware-Maryland Synod
Evangelical Lutheran Church in America
God's work. Our hands.

Testimony Prepared for the

Health and Government Operations Committee

on

House Bill 48

February 7, 2023

Position: **Favorable**

Madam Chair and members of the Committee, thank you for the opportunity to advocate for access to adequate and appropriate health care for all Marylanders. I am Lee Hudson, assistant to the bishop for public policy in the Delaware-Maryland Synod, Evangelical Lutheran Church in America, a faith community of congregations in three judicatories within our State.

Our community supports access to appropriate and adequate health care for all people in the United States: *We of the Evangelical Lutheran Church in America have an enduring commitment to work for and support health care for all people as a shared endeavor*, we said in our "Caring for Health" statement of 2003. So, we support **House Bill 48** because it can expand access to care in Maryland by implementing a coordinated care model for people receiving Maryland Medical Assistance.

Our understanding of "appropriate" and "adequate" applied to health care is that human life is an integrity of *soma* and *psyche*, body *and* spirit. Indeed, disorders labeled "behavorial" present as physical, that is acts with the body. Many psychological distresses are accompanied by, or present as, bodily distresses. For that reason, our community advocates *access to a basic level of preventive, acute, and chronic physical and mental health care at an affordable cost.*

Maryland has conducted a pilot in a care delivery model (Collaborative Care Model) in several State locations, following legislation passed in the 2018 session. The model integrates delivery of primary health care with behavioral/mental health services. A General Assembly report of February 2022 indicates that the model can improve outcomes for patients and achieve efficiency in the health care delivery system. It likely covers gaps in clinical practice.

House Bill 48 proposes making the delivery procedures of the CoCM pilot a care standard in Maryland's Medicaid program. We applaud and support this. Integrating care in this way is appropriate because the human condition is an integrity of body and spirit. For that reason, we urge your favorable report.

Lee Hudson

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MHAC letter in support HB 48.pdf
Uploaded by: Leslie Frey
Position: FAV

Montgomery County Mental Health Advisory Committee

February 7, 2023 **Written Testimony in Support of HB 48**

Delegate Joseline A. Pena-Melnyk
Chair, Health and Government Operations Committee
241 Taylor House Office Building
6 Bladen Street
Annapolis, MD 21401

Dear Delegate Pena-Melnyk:

The Montgomery County Mental Health Advisory Committee (MHAC) is pleased to support **House Bill 48 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion**, which will repeal the Collaborative Care Pilot Program, and require the Maryland Department of Health to expand access to and provide reimbursement for services provided in accordance with the Collaborative Care Model under the Maryland Medical Assistance Program.

MHAC was established to advise the Montgomery County Executive and the County Council on matters concerning mental health. Our work includes providing citizen oversight to all state-funded mental health agencies serving Montgomery County and serving as an advocate for a comprehensive mental health system for persons of all ages. The Committee helps to ensure that publicly funded mental health services are responsive to local needs, accountable to the citizenry and accessible to those in need. Our work includes closely following State and County legislative proposals relating to mental health. MHAC is comprised of citizen members who serve three-year terms without compensation that includes practicing physicians in the County, mental health professionals in the County who are not physicians, and individuals who are currently receiving or have in the past received mental health services as well as agency members that includes the Department of Health and Human Services, Montgomery County Public schools, and the Department of Juvenile Services.

HB 48 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated “clinically significant improvement” in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

MHAC supports CoCM as a way to increase access to mental health and substance use treatment and reduce barriers to getting care. The COVID-19 pandemic has had serious negative impacts on the mental health and psychological wellbeing of children, youth, and young adults and their families, particularly for groups at risk of new or exacerbated mental health and substance use challenges and those facing barriers to accessing care. The COVID 19 crisis has turned into a mental health and substance use crisis for young people. It is well documented that COVID-19 has led to diverse mental health problems, including anxiety, depression, posttraumatic stress disorder, and other trauma- and stress-related disorders. Youth suicides and overdoses have increased.

Currently, there are many barriers preventing adult consumers and families who have youth with behavioral health challenges from accessing mental health and substance use treatment. The workforce crisis has adversely affected the number of English speaking and bilingual behavioral health providers who provide services. This has resulted in increased wait lists for services and the ballooning labor burden on behavioral health providers who are struggling to meet the proliferated need for treatment. CoCM is key to reducing barriers to accessing treatment by integrating somatic and behavioral health services in primary care settings that includes (1) Care coordination and management; (2) Regular, proactive outcome monitoring and treatment for outcome targets using standardized outcome measurement rating scales and electronic tools, such as patient tracking; and (3) Regular systematic psychiatric and substance use disorder caseload reviews and consultation with a psychiatrist, an addiction medicine specialist, or any other behavioral health medicine specialist as allowed under federal regulations governing the model. Most people with mild to moderate behavioral health conditions first seek care in primary care settings. However, consumers with serious and persistent mental health challenges are more likely to be seen by specialty mental health providers, but often have limited access to effective medical care and experience high mortality rates. CoCM plays a critical role in helping to ensure that those with serious and persistence mental health challenges can access physical and mental health care.

There are significant health disparities among Black and Hispanic groups compared with Caucasian counterpart. CoCM will help to reduce heath inequalities. There are consumers and families from various cultural, racial, ethnic, religious, and socio-economic backgrounds who are more likely to engage in mental health and substance use treatment when it is delivered in primary care settings as this approach is less stigmatizing.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. **For these reasons, the Montgomery County Mental Health Advisory Committee urges this committee to pass HB 48.**

Sincerely,

Susan Kerin
Chair, Montgomery County Mental Health Advisory Committee

HB 0048- LWVMD- Maryland Medical Assistance Progra

Uploaded by: Nora Miller Smith

Position: FAV

LEAGUE OF WOMEN VOTERS® OF MARYLAND

TESTIMONY TO THE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE

HB 0048: Maryland Medical Assistance Program- Collaborative Care Model Services- Implementation and Reimbursement Expansion

POSITION: Support

BY: Nancy Soreng, President

DATE: February 7, 2023

The League of Women Voters Maryland supports **House Bill 0048: Maryland Medical Assistance Program- Collaborative Care Model Services- Implementation and Reimbursement Expansion, which would expand Medicaid recipients' access to behavioral health services in primary care settings.**

The League of Women Voters believes that every U.S. resident, including children, should have access to quality, affordable behavioral health care that is integrated with, and achieves parity with, physical health care. In its *Statement of Position on Health Care*, the League affirms that all people should have access to affordable, quality behavioral health care, and that **there should be efforts to decrease the stigmatization of, and normalize, behavioral health problems and care.**

Most patients' acute or chronic conditions are treated by their primary care providers. But most primary care providers concentrate on their patients' somatic problems. They have neither the time nor expertise to screen, evaluate, treat, and provide ongoing monitoring of common behavioral health issues such as anxiety, depression, or substance abuse. And due to the stigma associated with mental health conditions, patients are often hesitant to bring up these problems in the first place.

But behavioral health problems cannot be ignored. They directly impact a patient's health, and often, their life. Unidentified and untreated behavioral health conditions can lead to people in crisis. And people in crisis can wind up in emergency rooms, Intensive Care Units, jails, or morgues.

Clearly, it is crucial to increase easy access to behavioral health care and support. With passage of Senate Bill 0101 and expansion of the Collaborative Care Model, many of the barriers that have historically limited access to this care- especially for the most vulnerable populations in underserved communities- will be lowered.

121 Cathedral Street, Suite 2B, Annapolis, MD 21401
410-269-0232 * info@lwvmd.org * www.lwvmd.org

Per a 1/17/23 Washington Post article: "**Almost 40% of Maryland adults reported symptoms of anxiety or depression in February 2021…and about a third were unable to access counseling or therapy**." And according to figures from the National Alliance on Mental Illness[1] "**1,082,305 people in Maryland live in a community that does not have enough mental health providers**."

So this is also a matter of equity. Behavioral health care needs to be available to all Marylanders, regardless of where they live. And primary care settings are the optimal settings for this type of integrated care.

The Collaborative Care Model was first implemented in Maryland as a pilot program after passage of Chapters 683 and 684 of the Acts of 2018. With the success of the pilot, the program can now be expanded to serve more Medicaid enrollees who will benefit from **the availability of integrated somatic and behavioral health care within their primary care site. Patients will routinely be screened for symptoms of anxiety, depression, substance abuse, and other common behavioral health problems during their primary care visit, and if they are identified as needing support services, they will be referred to a behavioral health professional right then.** An appointment will be set up with a counselor, therapist, social worker, or addiction medicine specialist, who will then, as part of a team-based, patient-centered approach, help address **all** of the patient's health care needs.

This program is of vital importance, and for that reason we urge the committee to give a favorable report to House Bill 0048.

[1] https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf

HB0048_FAV_MedChi, MDAAP, MACHC, MdCSWC_Collaborat
Uploaded by: Pam Kasemeyer
Position: FAV

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TO: The Honorable Joseline A. Pena-Melnyk, Chair
Members, House Health and Government Operations Committee
The Honorable Heather Bagnall

FROM: Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Andrew G. Vetter
Christine K. Krone
410-244-7000

DATE: February 7, 2023

RE: **SUPPORT** – House Bill 48 – *Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, the Mid-Atlantic Association of Community Health Centers, and the Maryland Clinical Social Work Coalition, we submit this letter of **support** for House Bill 48.

In 2018, legislation was enacted that created a Collaborative Care Pilot Program. Under the Pilot Program, the "collaborative care model" is a patient-centered, evidence-based approach for integrating physical and behavioral health care services in the primary care setting. It includes care coordination and management, regular and proactive outcome monitoring and treatment using the standardized and validated clinical rating scale, and regular, systematic behavioral health caseload review and consultation for patients. House Bill 48 repeals the Pilot Program and instead requires the Maryland Department of Health (MDH) to provide reimbursement for services provided in accordance with the Collaborative Care Model statewide in primary care settings which provide health care services to Medicaid recipients.

While a report of findings and recommendations of the Pilot Program is due November 1, 2023, MDH provided a report on the Pilot Program in response to the 2021 Joint Chairman's Report. The preliminary results reflected in that report demonstrated a clinically significant improvement in depression and anxiety symptoms for more than 65 percent of participants in the Pilot Program. Furthermore, more than 20 other states are providing collaborative care models broadly to their Medicaid recipients. Commercial insurers and Medicare also provide reimbursement for delivering under this model.

Given the effectiveness of the Pilot Program to date as well as the recognized success of the model in other States and by other payors, there is no reason to maintain a pilot program. By expanding access to the proven Collaborative Care Model to all Medicaid recipients, House Bill 48 will improve the quality of behavioral health care delivered in primary care settings, where most people with mild to moderate behavioral health conditions first seek care.

House Bill 48 will improve behavioral health outcomes, help keep people out of crisis, and ultimately reduce costs due to early identification and intervention. A favorable report is requested.

Testimony In Support of HB 48 - SB 101- Health & G

Uploaded by: Rich Ceruolo

Position: FAV

February 3, 2023

Maryland Senate
6 Bladen St.
Annapolis, MD. 21401

In Support of SB 101 / HB 48: Maryland's Medical Assistance Program, Collaborative Care Model

Members of the Maryland House's Health and Gov't Operations Committee.

We are an organization of military and non-military families with over 1500 members and support our local non-profits that fill necessary roles in our non-profit support and services networks. We fully support SB 101 and the help that it will bring to all the citizens that benefit from the coordination of care and medical services offered to them through the Maryland Medical Assistance Program.

Collaborative Care Models of physical and mental health care services have been around for a while, decades within the medical community. There is real benefit to the communities that it serves in both the quality, the participation rates for patients in managed care programs, and overall cost management of these patient care programs for a variety of patient populations.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226460/

We would like to ask and encourage this committee to explore and expand the use and overall benefits of such a program through this type of care program. Especially as these programs impact a variety of communities including; Black, Brown, Disabled, the elderly or infirmed, Poor, Non-English Speakers, Veterans and Non-Veterans alike.

The future of Maryland's interlocking support service networks supports the lives of so many citizens. And the future care of all Maryland citizens relies on these networks and its service providers. Please support and protect the rights of citizens that access these medical assistance programs while improving access and the quality of these service offerings. We ask the committee to please support HB 24 / SB 101 and request that this committee return a favorable report.

Thank you for your time, and for considering our testimony.

Mr. Richard Ceruolo | Public Policy Director | richceruolo@gmail.com

Parent, Lead Advocate and Director of Public Policy Parent Advocacy Consortium
https://www.facebook.com/groups/ParentAdvocacyConsortium

2023 LCPCM HB 48 House Side FAV.pdf
Uploaded by: Robyn Elliott
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee:	**House Health and Government Operations Committee**
Bill Number:	**House Bill 48**
Title:	**Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion**
Hearing Date:	**February 7, 2023**
Position:	**Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports *House Bill 48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion.* This bill makes the Collaborative Care Model permanent in Maryland before the pilot sunsets in 2024.

LCPCM supports the Collaborative Care Model to provide much needed care coordination of physical and behavioral health services. Preliminary findings from 2021 indicate that patients enrolled in the program have shown clinically significant improvement despite the limited enrollment that was impacted by COVID-19.[1] We look forward to seeing the full report later this year, but are encouraged by the preliminary findings and believe they warrant continuing Collaborative Care Model in Maryland.

We ask for a favorable report. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

[1] https://health.maryland.gov/mmcp/Documents/FINAL%20CoCM%20Slides%202022%2002%2004.pdf

2023 MOTA HB 48 House Side FAV.pdf

Uploaded by: Robyn Elliott
Position: FAV

Maryland Occupational Therapy Association

PO Box 36401, Towson, Maryland 21286 ♦ www.mota-members.com

Committee: **House Health and Government Operations Committee**

Bill Number: **House Bill 48 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion**

Hearing Date: **February 7, 2023**

Position: **Favorable**

The Maryland Occupational Therapy Association (MOTA) supports *House Bill 48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion.* This bill makes the Collaborative Care Model permanent in Maryland before the Pilot sunsets in 2024.

Occupational therapists address barriers that individuals with mental health conditions experience in the community by providing interventions that focus on enhancing existing skills; remediating or restoring skills; modifying or adapting the environment or activity; and preventing relapse. As such, both the National Board for Certification in Occupational Therapy (NBCOT) and the American Occupational Therapy Association (AOTA) include mental health services within the scope of practice for occupational therapists.[1]

MOTA supports the Collaborative Care Model to provide much needed care coordination of physical and behavioral health services. Preliminary findings from 2021 indicate that patients enrolled in the program have shown clinically significant improvement despite the limited enrollment that was impacted by COVID-19. We look forward to seeing the full report later this year, but are encouraged by the preliminary findings and believe they warrant continuing the Collaborative Care Model in Maryland.

If we can provide any additional information, please feel free to contact Robyn Elliott at relliott@policypartners.net.

[1] National Board for Certification in Occupational Therapy – Certificate Renewal. https://www.nbcot.org/Certificants/Certification
American Occupational Therapy Association – Occupational Therapy's Role in Community Mental Health. https://www.aota.org/~/media/Corporate/Files/AboutOT/Professionals/WhatIsOT/MH/Facts/Community-mentalhealth.pdf

HB 48 written testimony.pdf
Uploaded by: Sarah Basehart
Position: FAV

HB48- Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

SUPPORT

Testimony of Maryland Centers for Independent Living

House Health and Government Operations Committee, February 7, 2023

The seven Centers for Independent Living (CIL) were established by federal law and work to ensure the civil rights and quality services of people with disabilities in Maryland. Centers for Independent Living are nonprofit disability resource and advocacy organizations located throughout Maryland operated by and for people with disabilities. CIL staff and Boards are at least 51% people with disabilities. We are part of a nationwide network providing the following core services: Information and Referral; Advocacy; Peer Support; Independent Living Skills training and Transition Services.

The Maryland Centers for Independent Living support HB48. Our staff and consumers know firsthand how difficult it can be to locate Behavioral Health Care, especially when Medicaid is your insurance. Requiring reimbursement for services provided within a Collaborative Care Model will increase the possibility that individuals with psychiatric needs using Medicaid will access the care and support they need to stay healthy.

The Collaborative Care Model allows individuals to seek more services in one location through a trusted primary care physician. It also allows physicians to work with behavioral health specialists to support the needs of their patient, a team approach that benefits the patient. This integrated method has be piloted in Maryland and used in other states producing positive results for individuals.

Contact Information:

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Hindley Williams
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PCC testimony written HB 0048.pdf
Uploaded by: Sarah Frazell
Position: FAV

primary care coalition

making
health care
happen

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TESTIMONY IN SUPPORT OF HB 0048:
Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

FROM: Sarah Frazell, Director of Behavioral Health Programs, Primary Care Coalition
DATE: February 7, 2023

My name is Sarah Frazell, and I am a licensed clinical social worker in the state of Maryland, and the Director of Behavioral Health Programs at Primary Care Coalition (PCC). The Primary Care Coalition (PCC) administers a variety of programs that provide a continuum of health services for uninsured and underinsured, ethnically diverse individuals who have limited resources and face other barriers to care.

Since 2005, the Primary Care Coalition has operated a successful Collaborative Care Model (CoCM) program right here in Maryland—the Montgomery Cares Behavioral Health Program (MCBHP). Because of the positive impact this program has had for our patients and community, the PCC supports HB 0048 to implement and expand reimbursement so that more Marylanders can receive the benefits of this effective model of care delivery.

The MCBHP embeds licensed behavioral health providers in five private nonprofit primary care clinics and serves around 1,300-1,600 patients annually (approximately 10-15% of all patients seen at the clinics where we operate) using the CoCM. The program is funded by the Montgomery County government and provides care to patients who live in Montgomery County, are uninsured/unable to access insurance, and live at 250% or below the federal poverty line. PCC hires and deploys behavioral health clinicians and consulting psychiatrists, in partnership with Medstar Georgetown, to community clinics. These staff serve as part of the clinic's team, working with

the nurses and primary care providers to identify and treat patients with depression, anxiety, PTSD, risky drinking, panic attacks, and intimate partner violence. The staff also assist providers in assessing crisis situations, often with the ability to connect patients with services and avoid unnecessary visits to the emergency room.

HB 0048 will improve the quality of behavioral health care delivered in primary care settings for Maryland Medicaid recipients by expanding their access to the proven CoCM.

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings, which is where most people with mild to moderate behavioral health conditions first seek care. The model uses a team-based approach to deliver (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic behavioral health caseload reviews and consultation for patients. CoCM has been validated in over 80 randomized controlled trials and shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalization and higher intensity levels of care.

The MCBHP tracks clinical outcomes and screening rates. We know now, that across the clinics where we work, at least 90% of patients have had at least one depression screen in the past year.

Commercial health insurers in Maryland and Medicare are already reimbursing providers for delivering this model. An ongoing CoCM pilot in the Maryland Medicaid program has demonstrated “clinically significant improvement” in depression and anxiety symptoms for more than 65 percent of participants. It is time to end the pilot and join the 20+ other states that are providing CoCM broadly to their Medicaid recipients.

As you are all aware, the COVID-19 pandemic has brought to light and exacerbated existing behavioral health concerns across the country. The CoCM model allows community members to have "in-house" support in clinics where they are already receiving care rather than requiring people to navigate complicated systems of accessing therapists or other services on their own. - a system that is already strained due to an insufficient number of psychiatrists and mental health therapists to meet the need of those looking for care.

In closing, I'd like to share an example of a patient who has had her life changed by the MCBHP CoCM. (Names and details changed to protect confidentiality)

When Josefina, a 42-year-old woman originally from El Salvador, attended her annual physical with her primary care provider, her pulse was high, and her provider asked if there was anything that was causing her stress. Josefina shared that she was not feeling safe at home. The primary care provider immediately called the Behavioral Health Care Manager, who met with Josefina right away. Josefina shared that while she didn't have any current concern about going home, she had experienced a history of abuse as both a child and adult, the traumatic loss of a partner in an accident, and was struggling with severe symptoms of depression, anxiety, and PTSD. Josefina had never considered seeking mental health services before and shared that she would not have known how to access these services on her own.

The Care Manager spoke with the consulting psychiatrist, who recommended an antidepressant and brief therapy, which was provided by the Care Manager. The primary care provider prescribed an antidepressant based on the psychiatrist recommendation, and the Care Manager provided medication education for Josefina, letting her know which side effects were common and

making
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happen

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that it could take some delay for her to notice a difference in her mood. In addition to providing counseling and medication management, the Care Manager also helped Josefina connect with services to help her with material needs such as internet, food, and clothing.

After just a few months of treatment, Josefina shared that her symptoms of anxiety, depression, and PTSD were very minimal and she felt happy and safe.

This bill will improve behavioral health outcomes, save money, and keep people out of crisis. For these reasons, Primary Care Coalition urges this committee to pass HB 0048.

Sincerely,

Sarah Frazell, LCSW-C
Director of Behavioral Health Programs
Primary Care Coalition

MDDCSAM - 2023 HB 48 FAV - Collaborative Care - Ho
Uploaded by: Scott Whetsell
Position: FAV

Maryland-DC Society of Addiction Medicine

A Chapter of American Society of Addiction Medicine

House Bill 48 - Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

SUPPORT

House Health and Government Operations Committee

February 7, 2023

The Maryland-DC Society of Addiction Medicine supports House Bill 48, which will make the ongoing financial support for the Maryland Medical Assistance Collaborative Care Model Service statewide. Research studies as well as local pilot programs at our University Hospitals and local medical practices have demonstrated superior patient outcomes when services are combined. Patients benefit by receiving recommended screenings, coordinated care with better management of chronic medical and serious mental health conditions, substance abuse treatment and treatment of infectious diseases.

This coordinated care model involves a team approach by several specialties and streamlines the delivery of care, providing a "one stop shop" access for patient convenience. It allows for direct communication among healthcare professionals and is a more holistic approach than traditional fragmented care where the patient may be seen in any number of locations by several providers who often have difficulty communicating with one another. This model not only improves patient care delivery, it saves money, promotes provider satisfaction and benefits the community at large.

Patients who receive primary care and behavioral health treatment in one place have better outcomes. Patients who receive treatment for their mental health and substance use disorders are able to reintegrate and become contributing members of their communities. Treatment of infectious diseases and substance use disorders also decreases spread of infections and expensive hospitalizations for consequences of ongoing active substance abuse.

In short support of this bill benefits everyone. We urge a favorable report.

15855 Crabbs Branch Way, Rockville, MD 20855 I mddcsam.org I info@mddcsam.org

MPA Testimony 2023 - Support with Amendments - Hou

Uploaded by: Pat Savage

Position: FWA

MARYLAND PSYCHOLOGICAL ASSOCIATION

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February 3rd, 2023

Delegate Joseline A. Pena-Melnyk, Chair
Delegate Ariana B. Kelly, Vice Chair
Health and Government Operations Committee
Room 241
House Office Building
Annapolis, MD 21401

RE: HB 48 Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion

Position: **Support, with Amendments**

Dear Chair, Vice-Chair and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the House Health and Government Operations Committee to **FAVORABLY report on HB 48, with the suggested AMENDMENTS we offer below.** HB 48 provides for Medical Assistance coverage of an integrative care model, known as the collaborative care model, which is currently funded as a pilot program. We support and encourage all integrated primary care and behavioral health models, one of which is the collaborative care model.

MPA has been working with stakeholders on this bill to allow all the evidence-based integrative primary and behavioral health models. We think it would limit access to care if Medical Assistance coverage was restricted to only the collaborative care model.

We would like to draw particular attention to page 2, line 11. The phrase "governing the model" on line 11 is a direct reference to the 2017 Medicare Physician Fee Schedule final rule defining the collaborative care model, which requires the inclusion of a psychiatrist on the care team to implement integrated care. In doing so, this model only recognizes 3 of the 4 Medicare-approved codes for behavioral health integration services. Access to psychiatric care in Maryland is already a significant problem, according to the recent Maryland Milliman Parity Report, and limiting who can participate in integrative primary and behavioral healthcare models will likely exacerbate this problem.

There are other evidenced-based models, which we propose being included as detailed in the amendments below:

Amendment #1:

Page 2, Line 2 – STRIKE "Collaborative Care Model means and evidence-based approach" and INSERT the following: "INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE MEANS THE COLLABORATIVE CARE MODEL, PRIMARY CARE BEHAVIORAL HEALTH MODEL, AND OTHER EVIDENCE-BASED APPROACHES FOR"

Amendment #2:

Page 2, Line 9 – After "psychiatrist" INSERT "PSYCHOLOGIST OR OTHER BEHAVIORAL HEALTH PROFESSIONAL" and in Line 11 STRIKE "governing the model"

Amendment #3:

Page 3, Line 28 – STRIKE "In Accordance with the Collaborative Care Model" and INSERT: "THROUGH INTEGRATED AND BEHAVIORAL HEALTH CARE, INCLUDING BUT NOT LIMITED TO THE COLLABORATIVE CARE MODEL, PRIMARY CARE BEHAVIORAL HEALTH MODEL, AND OTHER EVIDENCE-BASED APPROACHES"

Thank you for considering our comments and proposed amendments on HB 48. If we can be of any further assistance as the House Health and Government Operations Committee considers this bill, please do not hesitate to contact MPA's Legislative Chair, Dr. Pat Savage at mpalegislativecommittee@gmail.com.

Respectfully submitted,

Rebecca Resnik, Psy.D.

Rebecca Resnick, Psy.D.
President

R. Patrick Savage, Jr., Ph.D.

R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

2023 SB48 Written Testimony.pdf
Uploaded by: Deborah Brocato
Position: UNF

Opposition Statement HB48
Maryland Medical Assistance Program - Collaborative Care Model Services -
Implementation and Reimbursement Expansion
Deborah Brocato, Legislative Consultant
Maryland Right to Life

We Oppose HB48

On behalf of our 200,000 followers across the state, we respectfully object to HB48. This bill expands the Maryland Medical Assistance Program with an additional program called Collaborative Care Model Services. We oppose funds for this program being used for entities that promote and provide abortion and abortion services. We oppose expanding the Maryland Medical Assistance Program without excluding funding for abortion, abortion services and businesses providing those services.

The Collaborative Care Model Pilot Program shows that the "current pilot awardee" is Privia Medical Services, LLC which provides services at sites that include OB/Gyn services. On page 9, the *2021 Joint Chairmen's Report - Collaborative Care Pilot Updates* states "Privia Obstetric/Gynecology Practice - expected to enroll a population of 45 pregnant and postpartum individuals into CoCM per year who screen positive for depression." See health.maryland.gov/mmcp/pages/Collaborative-Care.aspx . Without language to prohibit funding of abortion and abortion services, reimbursements to the awardees of the Collaborative Care Program, in this case Privia Medical Services, could be used for abortion and abortion services.

The Maryland Medical Assistance Program and the Maryland Children's Health Program (MHCP) are the two primary programs used for publicly funded reimbursements to abortion providers in Maryland. The Maryland Department of Legislative Services, in their *Analysis of the FY 2022 Maryland Executive Budget*, shows that Maryland taxpayers are forced to fund elective abortions. For the years 2018, 2019 and 2020, over $6 million was spent each year for almost 10,000 abortions each year. In that same report, we see that for Fiscal 2020, less than 10 of the almost 10,000 abortions were due to rape, incest or to save the life of the mother.

Medical Assistance Expenditures on Abortion Language attached to the Medicaid budget since 1979 authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in Fiscal 1999. Without language to prohibit abortion funding, expansion of the Maryland Medical Assistance Program and MHCP will certainly increase the number of abortions and thus the amount of taxpayer money spent on abortions.

Opposition Statement HB48, page 2 of 2
Maryland Medical Assistance Program - Collaborative Care Model Services -
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Deborah Brocato, Legislative Consultant
Maryland Right to Life

Maryland is one of only 4 states that forces taxpayer funding of abortion. Maryland taxpayers are forced to subsidize the abortion industry through direct Maryland Medicaid reimbursements to abortion providers, through various state grants and contracts, and through pass-through funding in various state programs. Health insurance carriers are required to provide reproductive health coverage to participate with the Maryland Health Choice program. Programs involved in reproductive health policy include the Maryland State Department of Education, Maryland Department of Health, Maryland Family Planning Program, maternal and Child Health Bureau, the Children's Cabinet, maryland Council on School Based Health Centers, Maryland for the Advancement of School Based Health, Community Health Resource Commission, Maryland Children's Health Program (MCHP) and Maryland Stem Cell Research Fund.

Abortion is not healthcare and abortion is never medically necessary. A miscarriage is the ending of a pregnancy *after* the baby has died; an ectopic pregnancy is not a viable pregnancy and the baby cannot continue to develop. Abortion is the destruction of a developing human being and often causes physical and psychological injury to the mother. In the black community, abortion has reached epidemic proportions with half of pregnancies of Black women ending in abortion. The abortion industry has long targeted the Black community with 78% of abortion clinics located in minority communities. **Abortion is the leading killer of black lives.** See www.BlackGenocide.org.

Americans oppose taxpayer funding of abortion. Taxpayers should not be forced to fund elective abortions, which make up the vast majority of abortions committed in Maryland. The 2023 Marist poll shows that 60% of Americans, pro-life and pro-choice, oppose taxpayer funding of abortion. 81% of Americans favor public funds being prioritized for health and family planning services that save the lives of mothers and their children including programs for improving maternal health and birth and delivery outcomes, well baby care and parenting classes.

Funding restrictions are constitutional. The Supreme Court of the United States, in *Dobbs v. Jackson Women's Health* (2022), overturned *Roe v. Wade* (1973) and held that there is no right to abortion found in the Constitution of the United States. As early as 1980 the Supreme Court affirmed in *Harris v. McRae*, that *Roe* had created a limitation on government, not a government funding entitlement. The Court ruled that the government may distinguish between abortion and other procedures in funding decisions -- noting that "*no other procedure involves the purposeful termination of a potential life*", and held that there is "*no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds*."

For these reasons, we respectfully ask you to oppose **HB48**

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Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Acting Secretary

February 7, 2023

The Honorable Joseline A. Peña-Melnyk
Chair, House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, Maryland 21401

RE: HB 48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion – Letter of Information

Dear Chair Peña-Melnyk and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information for House Bill (HB) 48 – Maryland Medical Assistance Program – Collaborative Care Model Services – Implementation and Reimbursement Expansion. HB 48 will implement the collaborative care model (CoCM) statewide with a start date of October 1, 2023, which MDH has been piloting since July 2020. CoCM is an evidence-based model where primary behavioral health services are delivered in a primary care setting with the help of a behavioral health case manager and a consulting psychiatric provider.

MDH implemented the CoCM pilot program in July 2020, in accordance with HB 1682/SB 83 – Maryland Medical Assistance Program - Collaborative Care Pilot Program (Ch. 683 and 684 of the Acts of 2018). Preliminary results of evaluation efforts suggest that the CoCM Pilot Program has improved clinical outcomes. More than 65 percent of individuals enrolled in the intervention for more than 70 days demonstrated clinically significant improvement. For additional information, please see the 2021 Joint Chairmen's Report (p. 113-114) on the Pilot Program.[1]

MDH estimates that expanding CoCM statewide would cost approximately $20.9 million per year in total funds, with $8.2 million coming from State general funds and the remaining $12.8 million coming from federal matching funds.

If you have any questions, please contact Megan Peters, Acting Director of Governmental Affairs, at megan.peters@maryland.gov or (410) 844-2318.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Acting Secretary

[1] For additional information, please see the 2021 CoCM Pilot Program JCR: https://health.maryland.gov/mmcp/Documents/JCRs/2021/collaborativecarepilotJCRfinal11-21.pdf.