Children's Behavioral Health Coalition

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Senate Bill 201 Maryland Medical Assistance and Children's Health Insurance Programs - School-Based Behavioral Health Services - Reimbursement

Senate Finance Committee

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TESTIMONY IN SUPPORT WITH AMENDMENTS

The Maryland Children's Behavioral Health Coalition is comprised of representatives from mental health, consumer, family and professional associations all working together to improve the quality and accessibility of behavioral health assessment, treatment and recovery services for children and youth in Maryland. We are in support of Senate Bill 201, which has a goal of expanding access to behavioral health service access for children within our schools.

Over the past 10 years, Maryland has seen a marked decline in availability of services and supports for youth with behavioral health needs, and the results have been devastating. In 2010, just 1 percent of children 12 and younger with mental health problems stayed in the emergency department for longer than a day. By 2020, more than 10 percent were getting stuck more than a day – and sometimes weeks**.** The percentage of teens aged 13 to 17 staying more than 24 hours also rose sharply, from less than 3 percent to more than 13 percent.[1] From 2020-2021, Maryland saw a 46% increase in suicide attempt visits to the emergency department among those ages 0-17.[2] There is a youth mental health crisis in our state, and expanding access to care within schools is an integral piece of addressing this.

We are grateful to the leadership of the bill sponsors and recognize the ways it compliments the conversations happening now within the Consortium for Coordinated Community Supports. However, we want to ensure there are no unintended consequences of this bill, and as such request amendments to address a few key items:

Supplement not Supplant: Maryland has a robust infrastructure of partnerships between schools and community behavioral health providers. These community agencies employ mental health clinicians who work on site at hundreds of schools and to tens of thousands of Maryland's kids. They deliver services to children referred for care with Medicaid and many private insurances; most often, these providers then bill for these services under their outpatient mental health clinic. This model ensures that insurance participation is maximized, and that existing billing infrastructure is utilized to reduce duplication of effort. Students can also then take advantage of a wider array of behavioral health services offered in the community, which are available throughout the summer and holidays when school services are inaccessible. We would ask that this bill be sure to emphasize existing partnerships with community providers and ensure that services delivered with these funds are expanding behavioral health services in schools rather than replacing them.

Workforce Crisis: The disbursement of Kirwan funding over the past few years has shed light on how the workforce crisis can be exacerbated if funding and regional staffing plans do not work together. When counties made their own mental health hires directly, community providers saw significant turnover of their clinical workforce to positions in school mental health services paying higher salaries. The result is decreased access to services for children in the community even if access in schools might be temporarily

1 Wan, W. (2022, October 20). An autistic teen needed mental health help. He spent weeks in an ER instead. Washington Post. https://www.washingtonpost.com/dc-md-va/2022/10/20/er-mental-health-teens-psychiatric-beds/

2 Behavioral Health Administration Update to Maryland Behavioral Health Advisory Council, November 16, 2021

expanded. The loss of additional staff will lengthen waitlists, and potentially force community providers to exit current school partnerships.

Medicaid Billing Exclusions Complex Medicaid billing rules, including the prohibition of billing the same service in the same day, could pose potentially serious coordination challenges that could cause a reduction of service access for children and unbillable services for community providers. Currently, schools bill for some mental health services delivered to children with IEPs. As a result, community providers see a small number of services that they cannot bill for as the school has already done so for that child. If schools begin to bill Medicaid for services to more children, the increase in unbillable services for community providers will increase exponentially. Focus should be made to ensure this expansion of services is done in a way that does not disrupt the breadth of services offered within many school-community partnerships.

We applaud the intent of this bill and have already been in conversation with the bill sponsors about our concerns. We would hope that this bill could move forward with amendments that address these areas of concern, and ultimately help Maryland lead in expanding behavioral health service access to all school-age youth. We are happy to provide specific amendment language at the request of the Committee, and as such would **urge a Favorable report, with amendments to address the above concerns, on SB 201.**