SB 212_Carve In_Support.pdf
Uploaded by: Allison Taylor
Position: FAV

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

January 30, 2024

The Honorable Pamela Beidle
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 212 – Support

Dear Chair Beidle and Members of the Committee:

Kaiser Permanente is pleased to support SB 212, "Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations."

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

In recognition that the Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access have a similar mandate and overlapping membership, SB 212 takes steps to better coordinate and align the work of these two groups. We support this legislation as a mechanism to reduce duplication of effort by staff at the Maryland Department of Health and encourage the General Assembly to identify other opportunities to streamline the work of the hundreds of councils, commissions, and workgroups that touch on the health and wellbeing of Marylanders.

Kaiser Permanente also supports further study about the financing structure and quality oversight needed to integrate somatic and behavioral health services in the HealthChoice program. Individuals with behavioral health needs often experience co-occurring physical health conditions, and addressing these issues in silos can lead to fragmented care and suboptimal outcomes. By incorporating behavioral health services into managed care programs, a more comprehensive and coordinated care model can be established, ensuring that individuals receive integrated services tailored to their unique healthcare requirements.

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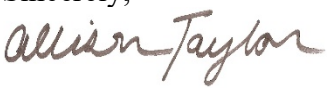
[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Permanente

SB212_BehavioralHealthAdvisoryCouncil_KennedyKrieg
Uploaded by: Emily Arneson
Position: FAV

Kennedy Krieger Institute

DATE: **January 30, 2024** **COMMITTEE: House Finance**
BILL NO: **Senate Bill 212**
BILL TITLE **Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations**
POSITION: **Support**

Kennedy Krieger Institute supports Senate Bill 212 Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations

Bill Summary:
Senate Bill 212 alters the membership of the Behavioral Health Advisory Council to include the Deputy Secretary for Developmental Disabilities or the Deputy Secretary's designee.

Background:
Kennedy Krieger Institute provides specialized services to patients nationally and internationally. Kennedy Krieger Institute is dedicated to improving the lives of children and young adults with developmental, behavioral, cognitive and physical challenges. Kennedy Krieger's services include inpatient, outpatient, school-based and community-based programs.

The Maryland Center for Developmental Disabilities (MCDD) at Kennedy Krieger Institute is proud to be Maryland's University Center for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD) and a member of the national Association of University Centers on Disabilities (AUCD).

MCDD links the community to vital services, research and information to improve the lives of people with disabilities. Our mission is to provide leadership that advances the inclusion of people with intellectual, developmental and other disabilities through preservice preparation and training; research and evaluation; community service and technical assistance; and information dissemination.

Rationale:
The MCDD supports greater representation and inclusion of people with developmental disabilities on councils across the state of Maryland and particularly on the Maryland Behavioral Health Advisory Council (the Council). The Council is charged with promoting and advocating for development of a coordinated, quality system of care that supports and fosters wellness, recovery, and resiliency, and health for individuals who have behavioral health disorders.

The work of the Council greatly impacts the lives of people with developmental disabilities as many individuals with developmental disabilities have co-occurring behavioral health conditions. It is estimated that about 33% of people with developmental disabilities are also diagnosed with a mental illness such as anxiety or depression[1] and many have challenging behavior.[2] Accordingly, the Council would benefit from a representative from a group that so frequently accesses behavioral health services.

Kennedy Krieger Institute requests a favorable report on Senate Bill 212.

Emily Arneson – AVP Government Affairs – arneson@kennedykrieger.org or 443-631-2188
707 North Broadway Baltimore, Maryland 21205 (443) 923-9200/Telephone (443)923-9125/Facsimile

[1] Maria Quintero and Sarah Flick, *Co-Occurring Mental Illness and Developmental Disabilities*, Social Work Today *10*(5), 6 (Sept. 2010), https://www.socialworktoday.com/archive/092310p6.shtml.
[2] D. L. Bowring, et al, *Prevalence of Challenging Behavior in Adults with Intellectual Disabilities, Correlates, and Association with Mental Health*, Current Developmental Disorders Reports, 6, 173-181 (Nov. 2019), https://link.springer.com/article/10.1007/s40474-019-00175-9.

8a - SB 212 - FIN - MDH - LOS.pdf
Uploaded by: Jason Caplan
Position: FAV

Maryland
DEPARTMENT OF HEALTH

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

January 30, 2024

The Honorable Chair Pamela Beidle,
Chair, Senate Finance committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 212-Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations – Letter of support

Dear Chair Beidle and Committee Members:

The Maryland Department of Health respectfully submits this letter of support for **SB 212** Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations.

This bill seeks to update the membership and terms of members for the Behavioral Health Advisory Council (BHAC) and support the Commission on Behavioral Health Care Treatment and Access in coordination with BHAC to study and develop recommendations on the financing structure and quality oversight necessary to integrate somatic and behavioral health services in the state Medicaid Program.

Last session, the General Assembly passed legislation establishing the Commission. Once appointments were made, the Commission quickly got to work and held meetings to review prior reports, engage in a needs assessment, and put forth recommendations for future initiatives. The Commission has completed an initial report to the legislature. Eleven Department employees provide day to day staff for the Commission, and the Commission also has the commitment of leadership dedicated to its work.

In parallel, federal law requires the Department to maintain a Behavioral Health Advisory Committee. This Committee is required in order to receive block grant funding from the Substance Abuse and Mental Health Services Administration. The goal of this legislation is to streamline efforts in order to maximize the effectiveness of stakeholder input. Many members of the Commission also sit on the Committee. This bill would allow for joint meetings and reporting and extends Commission reporting deadlines to reflect when the Commission was able to start meeting.

The bill also requires the Commission to research and make recommendations to the Governor and General Assembly regarding integrating behavioral health services into Maryland's Medicaid program. Maryland currently separates, or "carves out," Medicaid financing of behavioral health services from its Medicaid Managed Care Organizations (MCOs). This carve out, established in 1997 for mental health services, aligned with a national trend at the time that saw carving out behavioral health services as a promising approach to (1) protecting funding for behavioral health, (2) establishing specialty

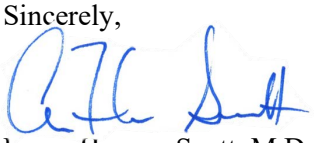
provider networks who could provide specialty behavioral health services, and (3) mitigating insurance plans from limiting their behavioral health benefits.[1,2]

In recent years, there has been a growing national discussion and shift to "carve-in" and integrate behavioral health to Medicaid MCO financing.[2,3] A key driver of this trend is that evidence has shown that strategies to enhance clinical integration of behavioral health and physical health can improve patient care outcomes.[2] Studies have shown that "carve-in" states outperform "carve-out" states by a wide margin, saving Medicaid $2.06 billion in state and federal expenditures, with notable changes including an overall decrease of 6% in Medicaid costs per prescriptions and a 14.6% lower net cost for the MCO-paid prescriptions than the average in the FFS states. [3] Similarly, a study done by the National Institutes of Health found that the financial integration of physical and behavioral health in Medicaid managed care was associated with greater access to behavioral health services, particularly for individuals with mild or moderate mental health conditions and for black enrollees, which can help advance the fight for health equity. The current "carve-out" and separate financing of care may inhibit reimbursement for services, create challenges in referring patients from primary care to behavioral health specialists, and impede communications, which altogether can have a detrimental impact on patient health outcomes.

Given the potential benefits and risks it is important for Maryland to assess next steps on behavioral health integration through research and stakeholder engagement. The recently established Commission on Behavioral Health Care Treatment and Access is tasked with reviewing research and making recommendations to guide the State on providing appropriate, accessible, and comprehensive behavioral health services. Adding the task of researching and making recommendations on integrating behavioral health services is an important next step to determine whether this is the right next step for Maryland.

If you have any further questions, please contact Sarah Case-Herron, Director, Office of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,



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

[1] Financial integration of behavioral health in Medicaid managed care organizations: A new taxonomy (2021) https://www.ohsu.edu/sites/default/files/2021-05/McConnell%20et%20al.%20Financial%20Integration%20of%20Behavioral%20Health%20in%20Medicaid.pdf

[2] Carve-In Models for Specialty Behavioral Health Services in Medicaid (2022) https://www.rand.org/pubs/research_reports/RRA1517-1.html

[3] "Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States – The Menges Group." *The Menges Group*, 16 April 2015, https://themengesgroup.com/2015/04/16/comparison-of-medicaid-pharmacy-costs-and-usage-in-carve-in-versus-carve-out-states/. Accessed 23 August 2023.

SB0212.docx.pdf
Uploaded by: Jonathan Dayton
Position: FAV

Statement of Maryland Rural Health Association (MRHA)
To the Senate Finance Committee
Chair: Senator Pamela Beidle
January 29, 2024
Senate Bill 0212: Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
POSITION: SUPPORT

Chair Beidle, Vice Chair Klausmeier, and members of the committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 0212: Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations

Altering the membership and requiring the Commission on Behavioral Health Care Treatment and Access to meet jointly with the Behavioral Health Advisory Council only encourages and promotes health equity and collaboration to improve mental health services across Maryland. We urge a favorable report.

On behalf of the Maryland Rural Health Association,
Jonathan Dayton, MS, NREMT, CNE, Executive Director
jdayton@mdruralhealth.org

MMCOA SB212 Behavioral Health - Comments in Suppor

Uploaded by: Joseph Winn

Position: FAV

MMCOA
MARYLAND MCO ASSOCIATION

Senate Bill 212 – Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations

SUPPORT

Senate Finance Committee
January 30, 2024

On behalf of the Maryland Managed Care Organization Association's (MMCOA) nine member Medicaid MCOs, thank you for the opportunity to submit these comments in support of Senate Bill 212 - Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations

Senate Bill 212 would increase the coordination and collaboration between the Behavioral Health Advisory Council, which was created in 2015 and the Commission on Behavioral Health Care Treatment and Access, created in 2023.

Additionally, the bill would require the Commission to make recommendations, in coordination with the Council, on the financial structure and quality oversight necessary to integrate somatic and behavioral health services.

The integration of somatic and behavioral health care continues to be an important public policy objective for the state. Maryland's MCOs remain committed to working towards the goal of integrating these services in order to deliver improved access and quality health services.

We believe the increased coordination between the Council and Commission will help to develop appropriate public policy recommendations such that Medicaid members see improved access to quality and timely behavioral health treatment. We support the passage of Senate Bill 212.

Please contact Joe Winn, Executive Director of MMCOA, with any questions regarding this testimony at jwinn@marylandmco.org.

SB212 FAV.pdf
Uploaded by: Morgan Mills
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

January 30, 2024

Chair Beidle, Vice Chair Klausmeier, and esteemed members of the Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a non-profit that is dedicated to providing education, support, and advocacy for persons with mental illnesses, their families and the wider community.

When the bill to establish the Commission on Behavioral Health Care Treatment and Access passed in 2023, NAMI MD was excited to get to work, as we're already heavily involved with the Behavioral Health Advisory Committee. However, once the Commission convened, we realized that some of the efforts between the two entities may be duplicative. We feel that it is in the best interest of the State to have both the Behavioral Health Care Treatment and Access Commission and the BHAC working together, in coordination, to ensure that Maryland's behavioral health care services are appropriate, accessible, and comprehensive across the State.

We urge a favorable report.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

SB 212 - BH Commission - 1-25-24-signed.pdf
Uploaded by: Suanne Blumberg
Position: FAV

Upper Bay Counseling & Support Services, Inc.

Suanne Blumberg, LCPC
Chief Executive Officer

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENT

I am Suanne Blumberg, CEO of Upper Bay Counseling & Support Services, Inc. Upper Bay Counseling has offices in both Cecil and Harford Counties. We offer a wide array of behavioral health services in the community for all ages, one through geriatric. We serve about three thousand individuals annually with serious mental illness in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

Upper Bay Counseling fully supports greater integration of behavioral health and somatic care services. We were awarded a grant in 2017 from the CHRC to place one of our social workers in the largest primary care practice in Cecil County. We also have an adult Health Home and a child Health Home incorporated into our Psychiatric Rehabilitation Programs (PRP).

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in model does not advance the clinical integration of care, while risking reduced access to care for those experiencing addiction or serious mental illness. There are very real and critical concerns that must be considered before a carve-in could be contemplated.

For these reasons, we support the amendment to SB 212 proposed by CBH. **The amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

We echo the request for the Finance Committee's support in urging MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/ behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendment.

Thank you for your time and consideration of the amendment.

Sincerely,

Suanne Blumberg, LCPC, CEO

[1] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.

[1] ***See, e.g.,*** Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA Health Forum.* 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

Chimes - SB 212 - BH Commission.pdf
Uploaded by: Bud DeFlaviis
Position: FWA

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENTS

I am Stephen DaRe, President and Chief Executive Officer of Chimes International Limited. Chimes is based in Baltimore and offers Acute and Intermediate Clinical Mental Health Services; Addiction Treatment; Life Skill Development, Residential Services, Vocational Programming, and In-Home Support Services to over 24,000 individuals annually with serious mental illness in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

Chimes fully supports greater integration of behavioral health and somatic care services. As a comprehensive provider of ambulatory, community-based, and residential behavioral health services, Chimes is recognized as an innovative and quality multi-service organization which includes state, regional, and international affiliates dedicated to services for individuals experiencing addiction, serious mental illness and intellectual/developmental disabilities. Our Behavioral Health Center of Excellence, Chimes Holcomb, offers a continuum of care designed to meet both behavioral health and somatic needs in Pennsylvania, Delaware, New Jersey and Maryland. Chimes Holcomb offers a "no wrong door" mentality with a total health care approach. Individuals and families across the lifespan can receive outpatient, medication management, medication-assisted treatment and group therapy in-person and via telehealth; nurses are employed to support physical health needs such as diabetes and blood pressure control, assistance with smoking cessation and guidance with weight management. As one of the nationally recognized 988 Suicide and Crisis Lifeline call centers, Chimes Holcomb offers 24/7 critical in-person and telephonic care to help individuals overcome crisis situations. Our interest is to continue expanding this critical work into Maryland via a CCBHC grant.

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in model does not advance the clinical integration of care,[1] while risking reduced access to care for those experiencing addiction or serious mental illness.[2] There are very real and critical concerns that must be taken into account before a carve-in could be contemplated.

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[1] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.

[2] *See, e.g.,* Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA Health Forum.* 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

For these reasons, we support the amendments to SB 212 proposed by CBH. **The first amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

A second proposed amendment for your consideration is to add language requiring MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with those amendments.

SB 212 - BH Commission - Cornerstone Testimony.pdf
Uploaded by: Cari Cho
Position: FWA

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care
Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENT

I am Cari Guthrie, the President and CEO of Cornerstone. Cornerstone is based in Montgomery, Calvert, Charles, and St. Mary's Counties and offers a full range of behavioral health services to over 3000 individuals each year with serious mental health and substance use disorders in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

Cornerstone fully supports greater integration of behavioral health and somatic care services. As one of the first federally recognized CCBHC's in Maryland in 2019, we have been expanding integrated care. We are co-located with an FQHC in one of our outpatient mental health clinics and with our third SAMSHA CCBHC grant we are going to be implementing our own primary care services in the next year. We have opened an onsite pharmacy, and we have a behavioral health home that coordinates care between our services and clients' medical providers. We have added CNAs to our residential program – serving 459 clients since 2019. Since implementing these integrated services, our medical hospitalizations have been reduced by as much as 35% and ED visits have reduced by over 60%.

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in model does not advance the clinical integration of care,[1] while risking reduced access to care for those experiencing addiction or serious mental illness.[2] There are very real and critical concerns that must be considered before a carve-in could be contemplated. The carve out allowed Maryland and providers to serve more people and to expand services in a way that had never been achieved previously. We have been able to focus on behavioral health needs directly without competing with medical funds. Carving the funds back into one bucket could send us back to the structure of the 80's and 90's with more people without needed behavioral health options. States that have taken away the carve out, now regret that choice. Studies have found that carve-ins are not more beneficial and in fact, design

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[1] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.

[2] *See, e.g.,* Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA Health Forum.* 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

[3] Horvitz-Lennon, M, Levin, JS, Breslau, J, et al. Carve-In Models for Specialty Behavioral Health Services in Medicaid: Lessons for the State of California. Santa Monica, CA: RAND Corporation, 2022. https://www.rand.org/pubs/research_reports/RRA1517-1.html

considerations are more important than the decision to finance behavioral health services as a carve-in versus carve-out[3]. We need to focus our efforts on the structure of the carve out model instead of revamping the entire system. The impact of a carve-in on the service array and the people themselves must be addressed before any changes are examined.

For these reasons, we support the amendment to SB 212 proposed by CBH. **The amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

We echo the request for the Finance Committee's support in urging MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendment.

SB 212 - BH Commission - FFCP.pdf
Uploaded by: Chandra Chester
Position: FWA

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care
Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENT

I am Chandra A. Chester, LCSW-C, Vice President and Co-founder of Families First Counseling and Psychiatry(FFCP). Families First Counseling and Psychiatry is based in Columbia, Baltimore City, Greenbelt and Olney and offers individual, family and couples therapy, medication management, Dialectical Behavioral Therapy (DBT), art therapy to 3000 individuals annually with serious mental illness in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

Families First Counseling and Psychiatry fully supports greater integration of behavioral health and somatic care services. When clients at FFCP face somatic symptoms, we're dedicated to guiding them towards the right care. We partner with community providers to offer comprehensive, integrated solutions for their specific needs.

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in model does not advance the clinical integration of care,[1] while risking reduced access to care for those experiencing addiction or serious mental illness.[2] There are very real and critical concerns that must be taken into account before a carve-in could be contemplated.

For these reasons, we support the amendment to SB 212 proposed by CBH. **The amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

We echo the request for the Finance Committee's support in urging MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater

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[1] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.

[2] *See, e.g.,* Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA Health Forum.* 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendments.

2024-01-29 - MD - Pyramid Healthcare - Testimony r

Uploaded by: Collan Rosier

Position: FWA

Pyramid Healthcare
AN INTEGRATED BEHAVIORAL HEALTHCARE SYSTEM

CORPORATE OFFICE
P.O. Box 967
Duncansville, PA 16635
P: 814-940-0407
F: 888-218-8253
pyramidhc.com

January 29, 2024

Delivered Via MyMGA Witness Signup Platform

The Hon. Pamela Beidle, Chair
Senate Finance Committee
Maryland General Assembly
3E Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

The Hon. Katherine Klausmeier, Vice Chair
Senate Finance Committee
Maryland General Assembly
123 James Senate Office Building
11 Bladen Street
Annapolis, MD 21401

RE: Pyramid Healthcare Favorable with Amendments Testimony re Senate Bill 212 – An Act Concerning "Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations"

Dear Chair Beidle, Vice Chair Klausmeier, and distinguished members of the Committee:

The Pyramid Healthcare, Inc. ("Pyramid Healthcare") family of companies is providing information and feedback below regarding Senate Bill 212, an act concerning "Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations." We support the bill with a crucial amendment supported by other behavioral healthcare providers.

As background, Pyramid Healthcare was founded in 1999 and is an integrated behavioral healthcare system that employs over 3,000 professionals caring for 12,000 unique commercial and Medicaid patients per day throughout our residential and outpatient locations across eight states. We offer a treatment continuum providing comprehensive behavioral healthcare specialties, including: substance use disorder, mental health, autism, and eating disorder treatment across an integrated network of service lines and affiliated behavioral healthcare organizations. In Maryland, Pyramid Healthcare operates 170 licensed behavioral healthcare treatment beds in additional to outpatient behavioral health treatment facilities across four locations which serve thousands of clients per year. In addition, we recently received approval for our certificate of need (CON) application to build a residential chemical dependency treatment center in Bowie, Prince George's County.

These facilities serve adult men and women with substance use disorder and co-occurring mental health disorders by providing medically-managed detoxification, short-term and long-term residential rehabilitation, partial hospitalization (PHP), and intensive outpatient (IOP) services as well as medication-assisted treatment (MAT) for opioid use disorder. All of our facilities are licensed by the State of Maryland and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The bill includes a new requirement that the Behavioral Health Commission make recommendations by the end of the year on the financing structure and quality oversight needed to integrate behavioral health services under Maryland Medicaid. Several behavioral health groups are urging support for the bill with an amendment to delay the due date of those recommendations by one year from January 1, 2025 to January 1, 2026. We agree and urge the Committee to delay the implementation of Section XXX of the bill by one year.

> (C) THE REPORT REQUIRED ON OR BEFORE JANUARY 1, ~~2025~~ [2026], SHALL INCLUDE THE COMMISSION'S FINDINGS AND RECOMMENDATIONS REGARDING THE FINANCING STRUCTURE AND QUALITY OVERSIGHT NECESSARY TO INTEGRATE SOMATIC AND BEHAVIORAL HEALTH CARE SERVICES IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM.[1]

This delay is essential to ensure sufficient time exists to transition the Maryland Medicaid Administrative Services Organization (ASO) contract to a new vendor.

Please consider this feedback and amend the legislation accordingly. Thank you for your support of behavioral health providers – including those in both mental health and substance use – in Maryland and for considering our policy proposals and recommendations on behalf of Pyramid Healthcare. If we can provide any additional information or materials, please contact me at crosier@pyramidhc.com or 667-270-1582. In addition, we invite you or a member of the Committee or staff to reach out and schedule a visit to one of our Maryland locations sometime soon to learn more about our programs and services.

Sincerely,

Collan B. Rosier
Vice President of Government Relations

[1] See p. 9, lines 2-6.

SB0212_MHAMD_FWA.pdf
Uploaded by: Dan Martin
Position: FWA

MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 212 Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations

Finance Committee

January 30, 2024

Position: SUPPORT WITH AMENDMENT

Mental Health Association of Maryland (MHAMD) 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 regarding SB 212.

SB 212 adds to the charges of the newly created Commission on Behavioral Health Care Treatment and Access by requiring that it make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health services in the Maryland Medicaid program. The bill requires these recommendations be submitted by January 1, 2025.

MHAMD is in full support of better integrating somatic and behavioral health care, and we applaud the General Assembly for passing a package of bills in 2023 that do just that. SB 101/HB 48 is expanding access to the proven Collaborative Care Model in Maryland Medicaid to improve the delivery of behavioral health care in primary care settings, and SB 362 will expand Maryland's network of Certified Community Behavioral Health Clinics (CCBHC), which are required by federal law to deliver integrated care. These are huge steps in furtherance of a public health care system that treats the whole person, mind and body.

Of course, we can always do better, and we are eager to engage in continued discussion about how to improve our system of care. But the devil is in the details. Three hundred thousand children and adults depend on the state for public mental health and substance use care. As we move toward greater integration, we must do so with an eye toward preventing a disruption in care for these individuals and with a recognition for the elements of Maryland's public behavioral health system that have made it one of the best in the nation, including:

- In addition to the Medicaid population, it covers uninsured and underinsured individuals, Marylanders 65 and older, and those who are dually insured by Medicare and Medicaid
- It provides a single point of contact and uniform processes for community mental health and substance use treatment providers, reducing administrative burden so that more resources can be used for direct service delivery
- It has a strong local management component to address different needs in different communities

These are just a few of the many issues and options that must be considered when determining how best to integrate somatic and behavioral health care in the Maryland Medicaid program. Given

this complexity, **we request an amendment that will extend the Behavioral Health Commission's reporting deadline from January 1, 2025 to July 1, 2025**. This will give the Commission enough time to thoroughly examine these issues and provide the legislature with the best recommendations on how to advance this worthy goal.

Upon adoption of this amendment, MHAMD supports SB 212 and urges a favorable report.

SB 212 - BH Commission - Lower Shore Clinic 2024.p
Uploaded by: Dimitrios Cavathas
Position: FWA

lower shore clinic

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENT

I am Dimitrios Cavathas, CEO of the Lower Shore Clinic, Inc. The Lower Shore Clinic is based in Salisbury and serves Wicomico, Somerset, Worcester, and Dorchester Counties. We offer a wide range of health services to 2000 individuals annually with serious mental illness and / or addiction issues in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

The Lower Shore Clinic fully supports greater integration of behavioral health and somatic care services. As a federally designated Certified Community Behavioral Health Clinic (CCBHC), we have been recognized as a leader in healthcare for providing integrated primary care with behavioral health care services. We are also designated as a Healthy People 2030 Champion by the U.S Department of Health. As a member of the Maryland Primary Care Program, we recognize the importance of integrated care. Most clients are insured by Medicaid, Medicare, or are uninsured, though the Clinic also accepts private payers and offers sliding fee scale billing. Lower Shore Clinic offers psychiatric evaluation, health promotion and maintenance, diagnosis and treatment of acute and chronic illnesses, medication management, medication assisted treatment, individual, group, and family services, assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, supportive housing, a psychiatric food "farmacy", and population health management programs. *This is a true integrated model of care.*

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in model does not advance the clinical integration of care,[1] while risking reduced access to care for those experiencing addiction or serious mental illness.[2] There are very real and critical concerns that must be taken into account before a carve-in could be contemplated.

[1] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.
[2] *See, e.g.,* Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA*

For these reasons, we support the amendment to SB 212 proposed by CBH. **The amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

We echo the request for the Finance Committee's support in urging MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendment.

Sincerely,

Dimitrios Cavathas
CEO
Lower Shore Clinic
www.lowershoreclinic.org

Health Forum. 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

SB0212_FWA_MedChi_BH Adv. Council & Comm. on BH Ca
Uploaded by: Drew Vetter
Position: FWA

MedChi

The Maryland State Medical Society

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TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
Chair, Senate Finance Committee (Maryland Department of Health)

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

DATE: January 29, 2024

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 212 – *Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports with amendment** Senate Bill 212.

Senate Bill 212 alters the membership and terms of members of the Behavioral Health Advisory Council and requires the Commission on Behavioral Health Care Treatment and Access to meet jointly with the Council. The bill also requires the Council to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health services in the Maryland Medical Assistance Program.

MedChi is supportive of the concept of taking a look at the current "carve out" of behavioral health services in Maryland and supports the position of the Maryland Psychiatric Society (MPS) regarding this matter. MedChi understands that MPS has submitted a package of amendments to this legislation; MedChi supports the MPS amendments. Further, MedChi supports MPS's position that a model, which is most likely to adopt a culture of integration, is also the one that will most likely reduce avoidable costs and improve the health care of this population. Integrating administration and management of mental health and substance use disorder treatment into the rest of healthcare has been shown to improve outcomes and reduce costs.

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

Legal Action Center Testimony SB212 _FWA_Behaviora
Uploaded by: Ellen Weber
Position: FWA

LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations (SB 212)
Finance Committee
January 30, 2024
FAVORABLE WITH AMENDMENTS

Thank you for the opportunity to submit testimony in favor of SB 212 with amendments. The bill would require the Behavioral Health Commission, in coordination with the Behavioral Health Advisory Council, to make recommendations no later than January 1, 2025 regarding the financing structure and quality oversight necessary to integrate somatic and mental health and substance use disorder services in Maryland's Medicaid program. This testimony is submitted by the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health (MH) and substance use disorder (SUD) services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance.

We urge the Committee to amend the proposed provision, § 13-4805(15), to require the Commission's recommendations to ensure compliance with the Parity Act as it examines the financing structure and quality oversight measures required to achieve integration of services. In addition to federal law, Maryland law, Health-Gen. § 15-103.6, requires Maryland's Medicaid program to comply with the Parity Act, and any recommendations related to Medicaid financing and service delivery must account for these non-discrimination requirements. We recommend the adoption of the following amendment:

> Make, in coordination with the Behavioral Health Advisory Council, recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health services and **ENSURE COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT** in the Maryland Medical Assistance Program."

Compliance with the Parity Act is a foundational requirement for any financing and service delivery model. **The Maryland Department of Health (MDH) is required, under federal law, to ensure compliance with the Parity Act regardless of the financing and delivery model. 42 C.F.R. § 438.920(b).** Under state law, (MDH must ensure that the Medicaid program complies with the Parity Act and address treatment limitations related to scope of benefits, billing limitations and reimbursement rates. Health-Gen. §15-103.6. In examining the financing structure for integrated services, the Parity Act requires Maryland to design and apply reimbursement rate setting practices, reimbursement policies, and scope and duration of benefit coverage that are comparable to and no more restrictive than reimbursement practices and benefit coverage for medical (somatic) services.

Similarly, the Parity Act standards are at the heart of quality oversight. The law's non-discrimination requirements serve as a quality measure as they apply to plan design features that directly affect patient access to care, including provider network composition, utilization review and authorization requirements and benefit coverage.

Reinforcing the State's Parity Act obligation in SB 212's proposed study and recommendations is important. To date, MDH has never evaluated whether its rate setting practices for MH and SUD benefits comply with the Parity Act. In 2023, as a result of concerns raised by Legal Action Center and other stakeholders, MDH removed some service limitations on MH and SUD benefits that were more restrictive than limitations that were applied to somatic care. Additionally, Legal Action Center has raised significant and on-going questions about the accuracy and sufficiency of MDH's parity analysis.

The integration of somatic and mental health and substance use disorder financing and services must also examine the **actual integration of care** for beneficiaries, which can be achieved under either a managed care or a fee-for-service financing and delivery system. As KFF reported in 2023, most states cover "at least some behavioral health services under FFS" and, of those, many also include some behavioral health services in a managed care arrangement. At the same time, states have also adopted service delivery models to intentionally focus on the need to address a patient's whole health care needs.

Maryland has taken important steps to provide integrated MH, SUD and somatic care under the carve-out and can take advantage of a new federal opportunity to enhance integrated care. Maryland's Chronic Health Homes has successfully integrated somatic, MH and SUD care for individuals receiving care in opioid treatment programs, mobile treatment services and psychiatric rehabilitation programs through the carve-out. Maryland is launching a Certified Community Behavioral Health Clinics (CCBHCs) demonstration, which many states pursue to integrate somatic, MH and SUD care. Finally, the Centers for Medicare & Medicaid Services (CMS) has just announced the Innovation in Behavioral Health (IBH) model to allow state Medicaid programs to promote somatic, MH and SUD care integration. The eight-year innovation model would allow Maryland to deliver integrated care in outpatient behavioral health practices regardless of its financing and delivery system. The model calls for MH and SUD practices to conduct screenings and assessments of MH, SUD and physical health and health-related social needs, offer treatment, provide "closed loop" referrals to other primary care providers, specialists and community resources, and conduct on-going monitoring. We urge MDH to apply for the IBH model as it further examines Maryland financing and delivery system.

Access to comprehensive and equitable MH and SUD care is critically important for Medicaid beneficiaries who have higher rates of mental illness and substance use disorders than privately-insured or uninsured individuals. Ensuring compliance with the Parity Act in service delivery and financing and pursuing the IBH model will help Marylanders obtain the comprehensive health services they need and are entitled to receive.

Thank you for considering our views. We urge the Committee to issue a favorable report with amendments on SB 212.

Ellen M. Weber, J.D.
Sr. Vice President for Health Initiatives
Legal Action Center
eweber@lac.org

DRMtestimony.SB212.pdf
Uploaded by: Leslie Margolis
Position: FWA

Disability Rights Maryland

Empowerment. Integration. Equality.

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SENATE FINANCE COMMITTEE

Senate Bill 212: Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access--Alterations

Date: January 30, 2024

Position: Support With Amendments

Disability Rights Maryland (DRM) is the protection and advocacy organization for the state of Maryland; the mission of the organization, part of a national network of similar agencies, is to advocate for the legal rights of people with disabilities throughout the state. One of the mandated purposes of DRM's legal work is to ensure that people with disabilities are included in their communities and that they have access to the supports and services that will make living and participating in community life possible. As an organizational member of both the Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access, DRM appreciates the opportunity to share our thoughts about Senate Bill 212, which would require joint meetings of the Council and the Commission and would require the two bodies to coordinate recommendations regarding the financing structure and oversight needed to integrate somatic and behavioral health services in the Maryland Medical Assistance Program; the bill requires a report by January 1, 2025.

DRM agrees that coordination between the Council and the Commission is important. At the first Commission meeting, the Maryland Department of Health provided Commission members with a summary of all of the reports that have been produced over the past decade addressing behavioral health in Maryland; it was striking to see the number of reports and the number of recommendations, and to consider how little coordination appears to have occurred over time between agencies. Holding joint meetings will help the policy-oriented Council and the Commission develop more comprehensive, non-duplicative recommendations.

Specifically with respect to Senate Bill 212's directive that the Council and Commission make recommendations regarding the financing structure necessary to integrate somatic and behavioral health services in the Medical Assistance program, DRM recommends that the legislation make clear that the Council and Commission should examine various funding models, including those that may be in use in other programs in Maryland and those that may be in use in other states; it is important for Council and Commission members to have data, relevant studies and other available information at hand in order to formulate informed recommendations. Those recommendations should take into account, not only the financial structure of integrated services, but also the impact of integrated services on patient/client privacy and the impact stigma may have on the ability to access both behavioral health and somatic services.

DRM also recommends adding additional members with lived experience to the Commission to ensure that the voices of a representative group of people who use behavioral health services are featured prominently in the policy discussions about the services that have such a significant impact on their lives. DRM further recommends that the timeline for the report be extended to January 1, 2026. When the Maryland General Assembly enacted legislation in 2023 to create the Commission, the Commission was given responsibility for 14 tasks; this set of recommendations and report would make the 15th obligation of the Commission. It is not feasible for the Commission, which held its second meeting only in December, 2023, to dedicate the time needed to thoroughly examine funding structure options and produce a report by January 1, 2025. Finally, we recommend that Senate Bill be amended to make clear that any recommendations to integrate somatic and behavioral health services must ensure compliance with the Mental Health Parity and Addiction Equity Act, federal legislation enacted in 2008.

The Commission and the Council working together offer a powerful opportunity to re-imagine what kinds of behavioral health services are provided to Marylanders and how those services are delivered. DRM supports Senate Bill 212 with these amendments in order to strengthen the work of the Council and the Commission and to ensure that in policy discussions about financial structure and integration of services, the perspectives and needs of the people for whom the system exists do not get lost. Please contact Leslie Seid Margolis, Managing Attorney and Policy Counsel for more information at lesliem@disabilityrightsmd.org or 443-692-2505.

SB212-CBH-FWA-FIN.pdf
Uploaded by: Lori Doyle
Position: FWA

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024

POSITION: SUPPORT WITH AMENDMENT

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based organizations serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

SB 212 amends the charge of the new Behavioral Health Care Treatment and Access Commission (SB 582/HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

CBH fully supports greater integration of behavioral health and somatic care services. We have made numerous recommendations to the Maryland Department of Health (MDH) over many years, including expanding the chronic behavioral health home program (which is an integrated care model) to outpatient mental health centers (OMHCs) where the majority of adults and children in the public system receive behavioral health services. We have been unsuccessful in that advocacy.

Last session the General Assembly passed a comprehensive package of behavioral health bills that will advance the cause of greater integration. These include SB 581 (Behavioral Health Care Coordination Value-Based Purchasing Pilot Program), which includes outcomes for both behavioral health and somatic care, and SB 362 (Certified Community Behavioral Health Clinics - Planning Grant Funds and Demonstration Application). Federal requirements for CCBHCs include integration of behavioral and somatic health.

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. A recent study examined Washington state's carve-in and concluded that the change in funding model did not advance the clinical integration of care.[i] There are very real and critical concerns that must be taken into account before a carve-in could be contemplated. These concerns would impact those receiving services, their families, and providers. That is why, in 2004, the General Assembly passed language requiring legislative approval prior to a carve-in of mental health services.

The complexity of the issue leads to our proposed amendments to SB 212. The current language requires a report on the integrated care recommendations on or before January 1, 2025, just 6 months after enactment of SB 212, should it pass. That is insufficient time to look at the various models of integration and to adequately weigh stakeholder input. **We therefore suggest striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." That will allow a full year to gather input and weigh the various integration options.**

We also ask for the Finance Committee's support in urging MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. This IBH model – announced by the Centers for Medicare and Medicaid Services (CMS) on January 18 will award up to eight states the opportunity to receive funding and implementation support for an 8-

year integrated care model. Community behavioral health organizations and providers who participate would receive a per-beneficiary-per-month payment to provide care integration (screening, assessment, referral and treatment) and care coordination to meet the somatic and behavioral health needs of the identified population. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO) is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendment.

For more information contact Lori Doyle, Public Policy Director, at (410) 456-1127 or lori@mdcbh.org.

[i] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.

LEGISLATIVE INITIATIVES RELATING TO MARYLAND'S BEHAVIORAL HEALTH CARVE-OUT

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

·**1996**. The Maryland General Assembly passed SB 750/HB 1051, which created the Medicaid managed care program known as HealthChoice. Specialty mental health services were carved out of the managed care program and placed under the management of the Mental Hygiene Administration. Medicaid managed care organizations (MCOs) were still responsible for primary mental health services and all Medicaid-covered substance use disorder services. The specialty mental health system could also include MCOs "that are cost-effective and that enter into agreements with the department to comply with the performance standards for providers in the delivery system for specialty mental health services; and comply with the quality assurance, enrollee input, data collection, and other requirements specified by the department in regulation." No MCO has ever participated in the specialty mental health system.

·**2004**. The Maryland General Assembly reiterated its support for the mental health carve-out by passing SB 756 / HB 943, which prohibited the Secretary of the then-Department of Health and Mental Hygiene from ending the carve-out or contracting with a behavioral managed care organization to provide specialty mental health services without prior legislative approval.

·**2015**. After more than two years of open meetings between the Maryland Health Department and stakeholders – including managed care organization reps, providers, consumers, family members and other advocates – the decision was made to maintain the mental health carve-out and also to carve out substance use disorder services.

·**2019**. Legislation was introduced (SB 482 / HB 846) that would have carved both mental health and substance use disorder services into the Medicaid MCOs. The bills were withdrawn after facing stiff opposition from behavioral health providers, family members, consumers, and other stakeholders. The chairs of the Senate Finance (Senator Delores Kelley) and Health and Government Operations (Delegate Shane Pendergrass) Committees wrote a letter to then-Secretary Dennis Schrader instructing him to bring the MCOs and various stakeholders together to examine the behavioral health system and make recommendations about its structure and whether it should be carved in or out of the MCOs. Work began in the System of Care meetings in 2019 but was disrupted by COVID before it could complete its charge.

·**2023**. Legislation (SB 582 / HB 1148) was passed creating a four-year Commission on Behavioral Health Care Treatment and Access. The Commission's charge is "to make recommendations to provide appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the state across the behavioral health continuum." Given that the System of Care workgroup was unable to complete its charge due to the disruption caused by COVID, this new Commission should grapple with the carve-in/carve-out issue as part of its comprehensive review of the system. The Commission's four-year timeline would dovetail well with the awarding of a new administrative services organization (ASO) in the Fall of 2023, with a contract expected to be in place from CY2024 through CY2029.

SB 212-LBE-Testimony.pdf
Uploaded by: Mary Rimi
Position: FWA

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENT

I am Mary Rimi, Outpatient Mental Health Director of Leading By Example LLC. Leading By Example is based in Nottingham Maryland, and offers behavioral health treatment, including therapy, medication management, case management, intensive in-home, health home, and psychiatric rehabilitation services to 1000 individuals annually with serious mental illness in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

Leading By Example fully supports greater integration of behavioral health and somatic care services. We have demonstrated this support within our current programming and throughout our organization. Since 2015 we incorporated Health Home services into our care to ensure coordinated support and interface between somatic and behavioral health care. Each year our health home program identifies a physical health initiative with targeted efforts to support our clients throughout the year. Across all of our service lines, our organization highlights the importance of somatic health care and collaboration to best support the community and all persons served, demonstrated through ongoing referral, collaboration notes, and required ongoing training on the interaction of somatic and behavioral health.

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in model does not advance the clinical integration of care,[1] while risking reduced access to care for those experiencing addiction or serious mental illness.[2] There are very real and critical concerns that must be taken into account before a carve-in could be contemplated.

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[2] *See, e.g.,* Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA Health Forum.* 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

For these reasons, we support the amendment to SB 212 proposed by CBH. **The amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

We echo the request for the Finance Committee's support in urging MDH to apply for the newly created Innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendment.

NCADD-MD - 2024 SB 212 FWA - Behavioral Health Com
Uploaded by: Nancy Rosen-Cohen
Position: FWA

Senate Finance Committee
January 30, 2024

Senate Bill 212

Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations

Support with Amendments

NCADD-Maryland supports Senate Bill 212 with an amendment. We fully support collaboration between the long-standing Behavioral Health Advisory Council and the new Behavioral Health Commission, created just last year. While there are separate statutorily required purposes for the two bodies, there is a great deal of overlap and a need to make sure there is collaboration.

NCADD-Maryland also believes it is appropriate for the Commission, in coordination with the Council, to examine and make recommendations regarding improved integration of somatic and behavioral health care in Medicaid. Having been a participant in discussions for many years on the topic of financing structures, we believe it is inappropriate to rush a new conversation, with new leadership at the Department, are require recommendations by the end of this year. We suggest amending the date to January 1, 2026.

There are many good examples of models where care is integrated or coordinated because of the way services are financed. Opioid treatment programs are among the treatment programs that can apply to be Health Homes, a proven effective model. Just last year, legislation put forth by the Maryland Behavioral Health Coalition turned on billing codes for the Collaborative Care model, as well as legislation to create the Value-Based Purchasing Pilot Program. And just last month, SAMHSA announced a new Innovation in Behavioral Health Model intended to "improve the overall quality of care and outcomes for adults with mental health conditions and/or substance use disorder by connecting them with the physical, behavioral, and social supports needed to manage their care." We hope Maryland is among the states to successfully apply to be part of this demonstration.

Additionally, NCADD-Maryland has worked diligently for a number of years as part of the Maryland Parity Coalition to ensure both public and private health coverage is in compliance with the federal Mental Health Parity and Addictions Equity Act, passed in 2008. There remains more work to be done to ensure full compliance with the federal law, and we ask that this be incorporated in the work regarding integration.

(over)

National Council on Alcoholism & Drug Dependence – Maryland Chapter
28 E. Ostend Street, Suite 303, Baltimore, MD 21230 · 410-625-6482 · fax 410-625-6484
www.ncaddmaryland.org

We therefore request the following amendments:

Amendment No. 1

On page 8, in line 3 and on page 9, in line 5, after "SERVICES" insert:

AND ENSURE COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Amendment No. 2

On page 9, in line 2, strike "2025" and replace with "2026."

With these amendments, we urge your support of Senate Bill 212.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

SB 212 Written Testimony from PDG 01-24-24 (2).pdf
Uploaded by: Sondra Tranen
Position: FWA

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1110 Benfield Blvd, Suite B, Millersville, MD 21108

Testimony on SB 212
Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations
Senate Finance Committee
January 30, 2024
POSITION: SUPPORT WITH AMENDMENT

I am Sondra Tranen, Executive Vice President of The Partnership Development Group, Inc. (PDG). PDG is based in Millersville and offers Behavioral Health, Trauma Treatment, and Case Management in the Anne Arundel County Detention Centers to about 1,500 individuals a year, and we offer Psychiatric Rehabilitation Services, Case Management, and Therapy to 450 individuals annually with serious mental illness in our community.

SB 212 amends the charge of the newly created Behavioral Health Care Treatment and Access Commission (SB 582/ HB 1148 from the 2023 session) to include a requirement to make recommendations regarding the financing structure and quality oversight necessary to integrate somatic and behavioral health care services in the Medicaid program.

PDG fully supports greater integration of behavioral health and somatic care services. We have a licensed Health Home for those participating in our Psychiatric Rehabilitation Program. The Health Home Program is designed to enhance person-centered care, empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. To meet this mission, the Health Home Program provides:

- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Independent and Family Support
- Referral to Community and Social Supports

In addition to the Health Home Program, PDG coordinates care with all consumers' treatment teams, including: their Primary Care Physicians; Substance Use treatment providers; family members and/or support persons; and any others the consumers wish to have involved in their treatment. Integrated care coordination is completed minimally every six months, and usually more frequently based on the individual needs of each participant.

While we support improvements to integrated care, we do not support turning over behavioral health to managed care entities (carve-in) to try to achieve that goal. Studies have indicated that the carve-in

model does not advance the clinical integration of care,[1] while risking reduced access to care for those experiencing addiction or serious mental illness.[2] There are very real and critical concerns that must be taken into account before a carve-in could be contemplated.

For these reasons, we support the amendment to SB 212 proposed by CBH. **The amendment suggests striking "January 1, 2025" on p. 9, line 2 and inserting "July 1, 2025." This change will allow the Commission to have a year – rather than just six months – to gather input and weigh the various integration options.**

We echo the request for the Finance Committee's support in urging MDH to apply for the newly created innovation in Behavioral Health (IBH) model. The IBH model is a new federal financing model to allow up to eight states to receive funding and implementation support for an integrated care model. This model is consistent with the value-based payment legislation you passed last year and is a way to move assertively toward greater somatic/behavioral health integration without becoming mired in the carve-in controversy. The Notice of Funding Opportunity (NOFO)is expected to be released in Spring 2024.

We urge a favorable report on SB 212 with this amendment.

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[1] McConnell KJ, Edelstein S, Hall J, et al. Access, Utilization, and Quality of Behavioral Health Integration in Medicaid Managed Care. *JAMA Health Forum.* 2023;4(12):e234593. doi:10.1001/jamahealthforum.2023.4593.

[2] *See, e.g.,* Auty et al. Association Between Medicaid Managed Care Coverage of Substance Use Services and Treatment Utilization. *JAMA Health Forum.* 2022;3(8):e222812 (Maryland's SUD carve-in was associated with a 104.4% relative increase in utilization, while Nebraska's SUD carve-out was associated with a relative decrease of 33.2%); Frank RG. Behavioral health carve-outs: Do they impede access or prioritize the neediest? Health Serv Res. 2021 Oct;56(5):802-804 (reduced use of specialty care for people with serious mental illness associated with carve-in model).

SB 212 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FWA

January 29, 2024

The Honorable Pamela Beidle
Finance Committee
Miller Senate Office Building – 3 East
Annapolis, MD 21401

RE: Support with Amendments – Senate Bill 212: Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations

Dear Chairman Beidle and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS enthusiastically support Senate Bill 212: Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations (SB 212) because for over decade our groups have been vocal supporters of changes to Maryland Medicaid that adopt a "culture of integration" with a focus on better integration of mental health (MH) and substance use disorder (SUD) with somatic care.

Before we expand upon that support, MPS/WPS request one clarifying amendment to the bill as follows:

Amendment 1

On page 4, in line 17, after “professionals,” insert “,ONE BEING A BOARD CERTIFIED PSYCHIATRIST”

Having a “medical professional” with the education, training, and experience of a board-certified psychiatrist can only assist the Behavioral Health Advisory Council and Commission with its important work in this space.

Returning to our reasons for supporting SB 212, MPS/WPS believe that a model that is most likely to adopt a culture of integration is also the one that will most likely reduce avoidable

costs and improve the health care of this population. Integrating administration and management of MH and SUD treatment into the rest of healthcare has been shown to improve outcomes and reduce costs, so much so that the legislature in 2023 voted to prematurely end a pilot Medicaid program that integrated care for just two counties and instead expand the program to all Medicaid participants across all Maryland counties.

Furthermore, MPS/WPS believe that future changes to Maryland behavioral health services should ensure that a culture of integration be hard-wired to contain the following features that ensure good outcomes:

1. Financial rewards and penalties for the payor(s) should be integrated in such a manner that they are incentivized to coordinate services and prevent negative outcomes regardless of who is paying the bill. If the ASO denies a service and this results in an $80,000 bill to the MCO for hospitalization after a suicide attempt, the ASO should be at risk for part of this bill. Similarly, if the MBHO provides case management services that results in improved diabetes care management that leads to reduced hospitalization costs for the MCO, the MBHO should share in those savings. There should be no opportunities for one payor to point to the other payor and say “not me.”

2. Financial rewards and penalties for the clinicians should also be integrated such that they are incentivized to pay attention to both somatic and behavioral health (BH) needs. This may include case management services that help behavioral health clinicians coordinate with somatic clinicians and services, as well as collaborative BH services that coordinate with PCPs.

3. Minimize administrative overhead such that the maximum proportion of expenditures are spent on direct care and coordination of services.

4. The spirit and letter of the Mental Health Parity and Addictions Equity Act should be proactively maintained. The payor must “provide a detailed analysis demonstrating that their utilization management protocols do not have more restrictive nonquantitative treatment limitations compared to those used on the somatic side.” The term “protocol” includes “...any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits.”

5. If the payor organization delegates any of its responsibilities to another contracted organization, it must “specify that the contractor shall comply with, and maintain parity between the MH/SUD benefits it administers and the organization's medical/surgical benefits pursuant to the applicable federal and/or state law or regulation and any binding regulatory or subregulatory guidance related thereto.”

6. Descriptions of the processes that the organization uses to ensure compliance with regulatory health care parity requirements, which include regulations pertaining to MH and/or SUD (MHPAEA), should continue including:

    - periodic internal monitoring and auditing of compliance
    - Periodic review and analysis to determine if there are any changes to its benefits, policies and procedures, and utilization management protocols that impact compliance
    - periodic communication to delegated contractors regarding changes impacting compliance, including parity of health care services such as mental health and/or substance use disorder parity (MHPAEA)

7. A comprehensive list of services and procedures that support integrated and comprehensive recovery models must be available to clinicians and consumers.

8. Integration must include all levels and aspects of care – Emergency Departments, all Inpatient Hospital Care, Partial Hospitalization, Nursing Homes, Assisted Living Facilities, Group Homes, Residential Programs, Day Programs, Outpatient Care, Diversion Programs, Pharmacy including all medications, and all types of care including MH, somatic, and addiction care.

9. Either require coordination of clinical information via the state-designated HIE or provision of a shared electronic health record service for all integrated care, with appropriate provisions to protect patient privacy.

10. Financial, administrative, and clinical data collection systems must be integrated to permit analysis of expenditures associated with patient outcomes.

11. Consumers should be allowed to receive services from any willing and competent clinician.

12. The comprehensive list of services that patients may receive must be developed using a recovery-based model and covered under the integration of services.

13. Data transparency for all stakeholders is critical for trust and success.

14. An oversight group of stakeholders will monthly review integrated data from all payor sources (MCO, ASO, MBHO, etc) and service utilization sources (CRISP, Pharmacy, etc) for the purposes of ongoing review and ensuring coordination of care.

15. Spreadsheets must be developed that permit ongoing ability for stakeholders to view levels of care being provided and denied, as well as their outcomes, for all patient subpopulations at a granular level.

16. Standards should be developed for network provider directories that ensure accurate and up-to-date contact information as well as the ability to indicate if a provider is recently accepting new outpatients in a timely manner.

Therefore, for all the reasons above and with the suggest clarifying amendment, MPS and WPS ask the committee for a favorable report on SB 212. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

8b - SB 212 - FIN - Boards - LOI.pdf
Uploaded by: Maryland State of
Position: INFO

Maryland State Board of Acupuncture
4201 Patterson Avenue, Third Floor
Baltimore, MD 21215

January 30, 2024

The Honorable Pamela Beidle
Chair, Finance Committee
3 East Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401-1991

RE: SB 212 Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations - Letter of Information

Dear Chair Beidle and Committee Members:

The Board of Acupuncture (the "Board") is submitting this Letter of Information for SB 212 Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations.

The Board is pleased to learn of the Department of Health's (the "Department") intention to coordinate decision-making about the access to the oversight and quality of behavioral healthcare treatment in our State.

Collaboration between the Behavioral Health Advisory Council (the "Council") and the Commission on Behavioral Health Care Treatment and Access (the "Commission") creates a well-rounded collective of subject matter experts and stakeholders, that will be well-positioned to design a comprehensive behavioral health services network for the diverse population of residents depending on the Maryland Medical Assistance Program for healthcare services.

The Board views this bill as an opportunity to optimize all the healthcare practice resources available under the Department's umbrella and recommends the Council and Commission further its goals by:

1. Ensuring that Acupuncture and East Asian Medicine (A&EAM) treatment is a behavioral health reimbursable service; and
2. Including Licensed Acupuncturists in the deliberative body membership of the Council and/or Commission.

There is an ever-evolving body of evidentiary documentation that details positive health outcomes of A&EAM in the treatment of mental health maladies, including but not limited to ADHD, anxiety, depression, trauma, and the associated symptoms. A few resources are as follows:

- Efficacy and Safety of Acupuncture on Childhood Attention Deficit Hyperactivity Disorder
- Why Psychiatrists are Recommending Acupuncture to Their Patients
- The Tao of Trauma: A Practitioner's Guide for Integrating Five Element Theory and Trauma Treatment

The Board appreciates the opportunity to comment on SB 212 and is open to further discussion. I can be reached at (410)764-5925 or tiffany.smith-williams@maryland.gov.

Sincerely,

Tiffany L. Smith-Williams, Executive Director
Maryland Board of Acupuncture

cc: file
Board Counsel
MD Acupuncture Society

The opinion of the Board expressed in this letter of information does not necessarily reflect that of the Department of Health or the Administration.