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.