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.