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