Inseparable 2026 - SB 428 FAV - Collaborative Care

Uploaded by: Angela Kimball

Position: FAV

inseparable

Senate Finance Committee
February 18, 2026

Senate Bill 428
Maryland Medical Assistance Program and Health Insurance—
Collaborative Care Model—Cost Sharing Prohibition
Support

Dear Chair Beidle, Vice Chair Hayes and Members of the Committee:

Thank you for the opportunity to submit written testimony in support of Senate Bill 428.

My name is Angela Kimball, and I serve as Chief Advocacy Officer for Inseparable, a national nonprofit organization founded on the principle that mental health is inseparable from physical health. Our work focuses on advancing evidence-based policies that strengthen access to high-quality behavioral health care.

Senate Bill 428 removes cost-sharing requirements for services delivered through the Collaborative Care Model, an evidence-based approach that integrates behavioral health treatment into primary care settings. This policy represents a strategic and effecti ve step toward expanding access to mental health care in Maryland.

The Collaborative Care Model is among the most rigorously studied interventions in behavioral health. Decades of research, including numerous randomized controlled trials, demonstrate that it improves outcomes for depression and anxiety, increases patient engagement in treatment, and produces more rapid symptom improvement compared to usual care. The model uses a coordinated team that includes a primary care provider, a behavioral health care manager, and a consulting psychiatrist. Care is measurement-based, systematic, and adjusted as needed to ensure clinical improvement.

Importantly, this model extends scarce psychiatric expertise into community-based primary care practices, including those serving rural and underserved populations. It enhances the capacity of the existing workforce while ensuring patients receive proactiv e and accountable care.

Even when services are available, cost-sharing can deter individuals from seeking or continuing treatment. For many Maryland residents—particularly those managing limited financial resources—copayments may present a meaningful barrier. In behavioral health care, delayed treatment is associated with worsening symptoms, increased emergency department utilization, higher overall health care costs, and significant human consequences.

By eliminating cost-sharing for Collaborative Care services in health plans, Senate Bill 428 removes a predictable barrier to accessing integrated behavioral health care. It reinforces the principle that mental health treatment delivered in primary care se ttings is essential health care.

This policy is also fiscally responsible. Evidence indicates that Collaborative Care reduces total health care expenditures over time by improving chronic disease management and reducing high-cost utilization, including hospitalizations and emergency servi ces. Early, coordinated intervention is both clinically effective and economically prudent.

Senate Bill 428 strengthens Maryland's behavioral health infrastructure, supports primary care practices, and promotes equitable access to evidence-based mental health treatment.

For these reasons, I respectfully urge a favorable report on Senate Bill 428.

Thank you for your consideration.

Respectfully submitted,

Angela Kimball
Chief Advocacy Officer
Inseparable
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SB0428_ChildrensBehavioralHealthCoalition_FAV.pdf
Uploaded by: Ann Geddes
Position: FAV

Children's Behavioral Health Coalition

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SB 428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition
Senate Finance Committee
February 18, 2026
Position: FAVORABLE

The Children's Behavioral Health Coalition (CBHC) brings together a wide range of advocates with a focus on policy issues and concerns specific to children and youth with behavioral health needs. We appreciate the opportunity to provide this testimony in support of SB 428.

SB 428 will improve uptake of the Collaborative Care Model (CoCM) by prohibiting Medicaid and commercial health insurers from imposing a co-pay, co-insurance, or deductible for services provided in accordance with the CoCM.

CoCM is an evidence-based approach for integrating physical and behavioral health care in primary care settings. The model includes:

1. care coordination
2. psychiatric consultation
3. measurement tracking

CoCM has been shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalizations and higher intensity levels of care.[1]

SB 428 would provide critically needed assistance for younger Marylanders. **Demand for behavioral health services by children and youth has never been greater, yet behavioral health providers are in short supply and becoming ever scarcer**. Data from the Youth Risk Behavior Survey of 2022-23 shows that 28% of Maryland high school students and 22% of middle school students reported that their mental health was not good most of the time or always, and 18% of high school students and 24% of middle school students reported that they had seriously considered suicide.[2] These numbers are at an all-time high. At the same time, data from a 2024 state assessment of Maryland's behavioral health workforce highlights an escalating crisis in access to care. According to the report,[3] today's workforce of 34,600 behavioral health professionals is 34% smaller than necessary to meet current demand, requiring an immediate influx of 18,200 individuals. An additional 14,600 workers will be required to replace those leaving the field by 2028, requiring a doubling of current capacity in just the next few years to keep pace with need.

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[1] Michael Yuhas etal. Mounting Evidence That Use of the Collaborative Care Model Reduces Total Healthcare Costs. The Bowman Family Foundation (2025). https://www.filesbff.org/CoCM_Total_Healthcare_Costs_Issue_Brief.pdf

[2] Maryland Department of Health releases 2022-2023 Youth Risk Behavioral Survey and Youth Tobacco Survey data. Maryland Department of Health. June 25, 2024. https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx

[3] Investing in Maryland's Behavioral Health Talent. Maryland Health Care Commission. October 2024. https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/md_bh_workforce_rpt_SB283.pdf

In addition to the ever-shrinking behavioral health workforce in Maryland, other barriers prevent families from seeking specialty mental health care for their child, including stigma and logistical barriers such as requiring more time off from work, and greater cost.

As a result, families turn to their child's pediatrician or primary care provider to access mental health care. A recent study found that between 2015 and 2023, the number of prescriptions for antidepressants and anti-anxiety medications prescribed by pediatricians for children nearly doubled.[4]

Yet mental health conditions in youth especially can be difficult to diagnose and to appropriately treat. Pediatricians express concern about their lack of mental health training and limited amount of time to spend with a patient.

The CoCM, by pairing a primary care provider with a care coordinator, providing psychiatric consultation, measuring progress, and ensuring adequate reimbursement solves these concerns.

Despite efforts in Maryland to increase use of the CoCM, data shows a drop-off of CoCM billing after an initial visit, which has been attributed to a reluctance among patients and families to pay additional out of pocket costs for important follow up visits. SB 428 would eliminate those out-of-pocket costs, a strategy that is a key recommendation in a recently released CoCM national report.[5]

SB 428 will improve behavioral health outcomes, save money, and keep people out of crisis. For these reasons, the Children's Behavioral Coalition urges a favorable report.

[4] Laura M. Pritchett etal. Patterns of Antidepressant and Antianxiety Medication Prescriptions in Primary Care in the U.S. Journal of Primary Care Community Health (2025). https://pubmed.ncbi.nlm.nih.gov/40525406/
[5] Michael Yuhas etal. (2025).

SB0428_MentalHealthAgingCoalition_FAV.pdf
Uploaded by: Ann Geddes
Position: FAV

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SB 428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition
Senate Finance Committee
February 18, 2026
Position: FAVORABLE

The Mental Health and Aging Coalition (MHAC) brings together a wide range of advocates from diverse professional backgrounds to focus on policy issues and concerns specific to older adults with behavioral health needs. We appreciate the opportunity to provide this testimony in support of SB 428.

SB 428 will improve uptake of the Collaborative Care Model (CoCM) by prohibiting Medicaid and commercial health insurers from imposing a co-pay, co-insurance, or deductible for services provided in accordance with the CoCM.

CoCM is an evidence-based approach for integrating physical and behavioral health care in primary care settings. The model includes:

1. care coordination
2. psychiatric consultation
3. measurement tracking

CoCM has been shown to improve health outcomes and save money, mostly via a reduction in unnecessary hospitalizations and higher intensity levels of care.[1]

SB 428 would provide critically needed assistance for older Marylanders. **Whereas all populations face barriers to accessing specialty behavioral health care, these challenges can be especially acute for older adults.** Stigma exists across all populations but is most prevalent among older Americans, who can be extremely averse to going to a specialty mental health provider. Limited mobility and access to transportation can also hinder getting to a mental health appointment. Finally cost, while a concern for all age groups, can be especially problematic for many older adults.

Yet older adults are not immune to behavioral health conditions. Nearly one in four adults over age 50 in 2024 had either a mental illness or substance use disorder, yet fewer than 50% received mental health treatment, and even fewer received substance use treatment.[2]

[1] Michael Yuhas etal. Mounting Evidence That Use of the Collaborative Care Model Reduces Total Healthcare Costs. The Bowman Family Foundation (2025). https://www.filesbff.org/CoCM_Total_Healthcare_Costs_Issue_Brief.pdf
[2] Olivia Dean etal. Barriers to Accessible and Affordable Mental Health and Substance Use Disorder Care for Older Adults. AARP (August 2025). https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/barriers-accessible-affordable-mental-health-substance-use-disorder-care-for-older-adults.doi.10.26419-2fppi.00377.001.pdf

For more information, please contact Ann Geddes at (443) 926-3396

On the other hand, often because of multiple somatic conditions, many older adults frequently visit their primary care provider. They build a strong relationship with a provider whom they come to trust and rely on for multiple concerns. This makes the CoCM a key intervention for this population.[3] Recognizing the critical role the CoCM can play in helping older adults with behavioral health conditions, an adaptation of the model was developed specifically for the older population - Improving Mood: Providing Access to Collaborative Treatment (IMPACT), which showed outstanding results and significant cost savings over time.[4]

Despite efforts in Maryland to increase use of the CoCM, data shows a drop-off of CoCM billing after an initial visit, which has been attributed to a reluctance among patients to pay additional out of pocket costs for important follow up visits. **Cost can be a real concern for older adults.** SB 428 would eliminate those out-of-pocket costs, a strategy that is a key recommendation in a recently released CoCM national report.[5]

SB 428 will improve behavioral health outcomes, save money, and keep people out of crisis. For these reasons, the Mental Health and Aging Coalition urges a favorable report.

[3] Pallavi Dham etal. Collaborative Care for Psychiatric Disorders in Older Adults: A Systemic Review. Can J Psychiatry (2017).
[4] Jurgen Unutzer etal. Long-term cost effects of collaborative care for late-life depression. Am J Manag Care (2008). https://pmc.ncbi.nlm.nih.gov/articles/PMC3810022/
[5] Michael Yuhas etal. (2025).

SB 428.pdf
Uploaded by: Ashley Clark
Position: FAV

MARYLAND PSYCHIATRIC SOCIETY

February 13, 2026

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

Support: Senate Bill 428: Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition

Dear Chairwoman Beidle & 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/WPS represent over 1200 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support Senate Bill 428: Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition. Collaborative care is a model to treat people with common mental health conditions in medical settings, mostly primary care. Most patients with mental health problems (such as anxiety, depression, PTSD, and alcohol and substance) talk to their primary care physicians (PCP) first, but PCPs often have multiple demands and do not always have the capacity to treat these disorders, especially given their shorter time they have with patients and the multiple health conditions they need to diagnose and/or treat. Collaborative care allows experts to collaborate with PCP to serve these patients, rather than referring them outside of the primary care setting, which can involve delays and expensive care. In collaborative care, a behavioral health care manager practices in the primary care clinic. The care manager is a mental health professional who works with the PCP and the consulting psychiatrist. The consulting psychiatrist provides expertise and support for the PCP, and treatment for patients in cases that need more specialized support.

Collaborative care is timely, effective, affordable, less costly for healthcare settings, and less stigmatizing as it allows access to psychiatric services within the primary care setting. Collaborative care is being used across the country and is now reimbursable. It also uses a registry to keep track of the patients served and to pay close attention to who needs more help and has proven to be more effective than usual care in over 80 randomized clinical trials. It also increases patient satisfaction.

SB428: Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model includes language prohibiting certain agencies and insurers from imposing "A COPAYMENT, 5 COINSURANCE, OR DEDUCTIBLE REQUIREMENT ON COVERAGE FOR SERVICES 6 PROVIDED IN ACCORDANCE WITH THE COLLABORATIVE CARE MODEL," which would encourage the utilization of collaborative care. As such, MPS and WPS ask the committee for a favorable report on SB428.

If you have any questions regarding this testimony, please contact MPS lobbyist, Lisa Harris Jones at lisa.jones@mdlobbyist.com.

Respectfully Submitted,
The Maryland Psychiatric Society & Washington Psychiatric Society
Legislative Action Committee

SB428 - Cari Guthrie Testimony.pdf
Uploaded by: Cari Cho
Position: FAV

Testimony on SB438
Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition
Finance Committee
February 18, 2026

POSITION: FAVORABLE

My name is Cari Guthrie, President and CEO of Cornerstone. Since 1971, Cornerstone has offered behavioral health services to people ages 5 and up in Calvert, Charles, St. Mary's, and Montgomery Counties. We currently serve over 3000 clients.

Our clients often have co-occurring physical health issues along with their behavioral health issues. These issues are the same as the general population – diabetes, hypertension, heart disease, and obesity. People with behavioral health issues have a difficult time following instructions from physicians regarding health. They struggle to buy and eat nutritious foods, they tend to avoid exercise, they do not want to pay additional co-pays, and they often do not attend their doctor appointments consistently. Anything that can be put in place to help address these issues is integral to stable quality of life. The Collaborative Care Model is patient centered, evidence-based practice for integrating physical and behavioral health care in primary settings. Multiple research trials have shown that it improves health and thus reduces costs in the healthcare system.

According to a report from Maryland Health Care Commission, Maryland needs to double its workforce by 2028 to keep pace with the need. The report recommends using the collaborative care model to help address these workforce challenges. Unfortunately, data shows a drop from Collaborative Care billing after a patient's first visit – which limits any benefits of the model. This decline is attributed to patients being unwilling and unable to pay the addition out of pocket costs for the follow up visits in this model. Cost, as stated above, is one of the barriers to Cornerstone clients accessing the care that they need.

SB428 eliminates those out-of-pocket costs – which is also a key recommendation in a new Collaborative Care Model national report that came out just last week. Eliminating these costs will give Cornerstone clients a lower barrier to accessing care. It will give Cornerstone staff more leverage to support and encourage our clients to attend those follow-up appointments and get the care that they need. People with behavioral health disorders die 25 years earlier than the general population. They are dying from the same diseases as everyone else, but their behavioral health disorders add challenges to their recovery.

Cornerstone's mission is to empower people with behavioral health disorders to thrive in their community through collaboration, treatment, education, and advocacy. We are bearers of hope, committing to helping them live a life of their choosing. Approving SB428 is an obvious next step to

improve access to effective health care so that they can improve their health, be productive members of their community, and have a quality life of their choosing. Please vote in favor of SB428.

Thank you.

SB0428 - Maryland Medical Assistance Program and H

Uploaded by: Cecilia Plante

Position: FAV

TESTIMONY FOR SB0428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition – FAVORABLE

Bill Sponsor: Senator Augustine
Committee: Senate Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Jessica Gorski, Executive Committee
Position: FAVORABLE

Chair, Vice Chair, and Members of the Committee,

My name is Jessica Gorski, and I am submitting this testimony in strong support of SB0428 on behalf of the Maryland Legislative Coalition. We are a statewide coalition of grassroots activist organizations representing well over 30,000 Marylanders across every legislative district. Our mission is to promote legislation in areas such as education, the environment, public safety, healthcare, and social justice that support all Marylanders and improve their lives. We put the power of the people to work in shaping legislation in Maryland.

SB0428 is essential for expanding access to integrated behavioral health care by prohibiting cost-sharing for services delivered under the Collaborative Care Model (CoCM). This evidence-based model embeds behavioral health support directly into primary care settings, improving early identification, treatment adherence, and long-term outcomes. For many Marylanders, especially those enrolled in Medicaid or covered by regulated carriers, even modest copays can deter them from seeking care. This bill removes that barrier and ensures that cost is never a reason someone goes without needed behavioral health support.

The threat of cost-sharing has long been a structural barrier that prevents individuals from accessing timely mental health care, exacerbating chronic conditions and increasing reliance on emergency services. SB0428 eliminates that barrier, strengthening Maryland's behavioral health infrastructure and ensuring that patients receive coordinated, whole-person care.

When people can access behavioral health services without financial obstacles, communities become healthier and more stable. This bill encourages early

intervention, reduces avoidable hospitalizations, and supports better management of chronic conditions—particularly for individuals whose physical and behavioral health needs intersect.

This legislation also reflects a trauma-informed and equity-centered approach. Cost-sharing requirements disproportionately impact Low-income Marylanders, individuals with chronic illnesses, and marginalized communities. Removing these costs affirms Maryland's commitment to fairness, dignity, and accessible care for all.

On a personal note, this bill resonates deeply with me. My husband has lived with advanced cardiac sarcoidosis since 2012, and heart-health monitoring has been a constant part of our lives every single week. I have seen firsthand how essential integrated behavioral health support is for patients managing complex, chronic conditions. Ensuring that Marylanders can access these services without cost barriers is not only sound policy—it is compassionate and life-changing.

SB0428 aligns directly with the mission of the Maryland Legislative Coalition. It advances public health, supports social justice, and strengthens Maryland's commitment to accessible, integrated care. By removing financial barriers to the Collaborative Care Model, this bill promotes healthier families and communities across the state.

I appreciate your consideration. **We respectfully urge a FAVORABLE report on SB0428**.

Jessica Gorski
Executive Committee
Maryland Legislative Coalition

MC Federation of Families Testimony in Support SB

Uploaded by: Celia Serkin

Position: FAV

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February 18, 2026

Senate Finance Committee
TESTIMONY IN SUPPORT
SB 428 Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model - Cost Sharing Prohibition

I am Celia Serkin, Executive Director of the Montgomery County Federation of Families for Children's Mental Health, Inc. (MC Federation of Families), a family peer-led support organization serving diverse families in Montgomery County who have children, youth, and/or young adults with mental health, substance use, or co-occurring challenges. MC Federation of Families has been providing family peer services to families in Montgomery County for 20 years. Our Family Peer Specialists are parents who have raised or are currently raising children with these challenges. I am a Montgomery County resident and have two children, now adults, who have struggled since childhood with behavioral health challenges. My son has suffered from debilitating depression for many years. My daughter is a Certified Peer Recovery Specialist who has lived experience with co-occurring challenges.

MC Federation of Families strongly supports SB 428 Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model - Cost Sharing Prohibition. The bill prohibits Medicaid and commercial carriers from imposing a copay, coinsurance, or deductible for behavioral health services provided via the Collaborative Care Model (CoCM).

MC Federation of Families urges the Senate Finance Committee to support SB 428. CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings. The model has been validated in over 90 randomized controlled trials and shown to improve health outcomes and reduce costs.[1]

According to a 2024 report from the Maryland Health Care Commission, Maryland would need to double its current behavioral health workforce by 2028 to keep pace with the need.[2] CoCM is an important strategy for addressing Maryland's behavioral health workforce crisis, especially in rural areas. It expands the reach of the existing workforce, allowing providers to treat up to 8x the number of patients they can in traditional one-to-one settings. CoCM was identified in the Maryland Health Care Commission 2024 behavioral health workforce report as a key strategy for addressing the state's workforce challenges long term.

CoCM is one of very few specific interventions in medicine shown to reduce disparities by race/ethnicity and/or socioeconomic status in patients' access to care, quality of care, and outcomes. Given

limited access to specialty mental health care in the United States, CoCM allows psychiatric expertise to reach an exponentially larger group of patients, including children and youth with behavioral health challenges and their families.

Increasing the use of CoCM across Maryland is vital. State partners have stated that data shows a drop-off of CoCM billing after a patient's first visit, which totally defeats the benefit of the model. The decline in billing after the initial appointment is being attributed to a reluctance among patients to pay additional out of pocket costs for the important follow-up visits. SB 428 would eliminate those out-of-pocket costs, a strategy that is a key recommendation in a timely new CoCM national report that came out just last week.[3]

MC Federation of Families asks the Senate Finance Committee to support SB 428.

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[1]Yuhas, M. A.; Raines, L.; Glastra, J. Glastra, M. B. Bowman, B. A. Middlebrook, B. A. Harbin, H. T. (November 2025). Mounting Evidence That Use of the Collaborative Care Model Reduces Total Healthcare Costs, 2nd Ed. The Bowman Foundation. CoCM Total Healthcare Costs Issue Brief 2025.pdf

[2] Andy Hall, Aaron Korn, Kweilin Waller, and Josh Shapiro, PhD, with Trailhead Strategies. (October 2024). Investing in Maryland's Health Behavioral Talent, Maryland Health Care Commission and the Maryland Department of Health. INVESTING IN MARYLAND'S BEHAVIORAL HEALTH TALENT |

[3] PROGRESS REPORT Psychiatric Collaborative Care Model (CoCM). The Bowman Foundation / MHTARI (Mental Health Treatment and Research Institute). (February 2026). COCM_Progress_Report.pdf

SB0428_MHAMD_FAV.pdf
Uploaded by: Dan Martin
Position: FAV

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Senate Bill 428 Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition
Finance Committee
February 18, 2026
Position: FAVORABLE

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 in strong support of Senate Bill 428.

SB 428 prohibits Medicaid and commercial carriers from imposing a copay, coinsurance, or deductible for behavioral health services provided via the Collaborative Care Model (CoCM). **This bill is a priority for the Maryland Behavioral Health Coalition.**

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings. The model has been validated in over 90 randomized controlled trials and shown to improve health outcomes, mitigate behavioral health workforce challenges, and reduce disparities in access to care. There is also mounting evidence that use of CoCM reduces total healthcare costs.[1]

The Maryland General Assembly has taken steps in recent years to expand access to this model. Unfortunately, state data shows a drop-off of CoCM billing after a patient's first visit, which defeats the purpose and negates the benefits of the model. The decline in billing after the initial appointment has been attributed to a reluctance among patients to pay additional out-of-pocket costs for the important follow-up visits. SB 428 would address this issue by eliminating those out-of-pocket costs. This approach was recommended as a key CoCM expansion strategy in a timely new national report issued earlier this month.[2]

Increasing the uptake of CoCM across primary care providers is a critical component of Maryland's broader efforts to expand access to quality mental health care and reduce overall health care costs. **For these reasons, MHAMD supports SB 428 and urges a favorable report.**

[1] https://www.filesbff.org/CoCM_Total_Healthcare_Costs_Issue_Brief.pdf
[2] https://filesmhtari.org/COCM_Progress_Report.pdf

For more information, please contact Dan Martin at (410) 978-8865

SB 428_CoCM No Cost Sharing_BHSB_FAVORABLE.pdf
Uploaded by: Dan Rabbitt
Position: FAV

Behavioral Health System Baltimore

February 18, 2026

Senate Finance Committee
TESTIMONY IN SUPPORT
SB 428 – Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model – Cost Sharing Prohibition

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 100,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.

Behavioral Health System Baltimore supports SB 428 - Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition. The Collaborative Care Model (CoCM) is one of the most effective ways to integrate behavioral health into primary care and treat behavioral health issues early before they progress. Eliminating cost sharing for this key intervention will help to increase Maryland CoCM uptake and will save the state and its insurance carriers money in the long run.

CoCM is a high value intervention that allows primary care providers to consult with behavioral health experts and consultants to treat mild to moderate behavioral health conditions in the primary care setting. This reduces specialty behavioral health care costs and allows individuals to obtain support in a setting where they are already comfortable. This consultation can do a lot to treat moderate behavioral health needs and gives support to the primary care provider in treating behavioral health symptoms. This form of early intervention is effective and has been shown in numerous studies to lower total health care costs.[1]

Maryland made significant progress when expanding CoCM coverage several years ago, but adoption has been slow. CoCM patients also have not maintained the service for the recommended length of time. One of the key drivers of this is the cost sharing requirements. Out-of-pocket costs can be considerable and contribute to reduced access. Cost sharing is generally intended to manage utilization and contain costs, but increased CoCM use reduces costs itself. SB 428 would eliminate cost sharing for CoCM to increase CoCM and help manage Maryland's behavioral health care costs. This would help increase access and address Maryland's behavioral health workforce shortage.

Maryland should do all that it can to increase access to CoCM services and further integrate behavioral health into the primary care setting. **BHSB urges the Senate Finance Committee to support SB 428.**

For more information, please contact BHSB Policy Director Dan Rabbitt at 443-401-6142

Endnotes:

[1] The Bowman Family Foundation & the Mental Health Treatment and Research Institute. Psychiatric Collaborative Care Model Progress Report. February 2026. Available at https://filesmhtari.org/COCM_Progress_Report.pdf.

SB0428_FAV_MedChi, MDAAP_MMAP & HI - Collaborative
Uploaded by: Danna Kauffman
Position: FAV

MedChi

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Maryland Chapter
American Academy of Pediatrics
Speaking for Maryland Kids!

Senate Finance Committee
February 18, 2026
Senate Bill 428 – *Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition*
POSITION: SUPPORT

On behalf of MedChi, The Maryland State Medical Society, and the Maryland Chapter of the American Academy of Pediatrics, we submit this letter of **support** for Senate Bill 428. This bill states that neither the Maryland Department of Health nor a commercial health insurer may impose a copayment, coinsurance, or deductible requirement for services provided under the Collaborative Care Model (CoCM) statewide in primary care settings that provide health care services to recipients.

Enacted through legislation in 2018, the CoCM is an evidence-based, team-driven approach that integrates behavioral health services into primary care by pairing primary care providers with care managers and psychiatric consultants to deliver coordinated, measurement-based treatment. Eliminating cost sharing in the CoCM will have a positive effect by increasing patient engagement, improving clinical outcomes, and reducing the likelihood of costly downstream care.

Behavioral health treatment requires frequent follow-up care. When cost sharing is eliminated, patients are more likely to initiate and continue crucial therapy. If each encounter requires cost-sharing, patients may stop treatment, especially among Medicaid recipients with lower incomes who face transportation and other financial barriers. If treatment is stopped prematurely, there is a greater risk for emergency department visits, hospitalizations, and worsening of conditions. Therefore, we believe that Senate Bill 428 is the next step in building on and creating a successful model. We urge a favorable vote on Senate Bill 428.

For more information call:
Danna L. Kauffman
J. Steven Wise
Andrew G. Vetter
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410-244-7000

2026 Session - MHCC - SB 428_Collaborative Care Mo
Uploaded by: David Sharp
Position: FAV

MARYLAND
Health Care
Commission

Marcia Boyle, MS, Acting Chair
Douglas Jacobs, MD, MPH, Executive Director

2026 SESSION
POSITION PAPER

BILL NUMBER: **SB 428**

COMMITTEE: **Finance**

POSITION: **Support**

TITLE: **Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition**

BILL ANALYSIS

SB 428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition prohibits the Maryland Department of Health and certain payers from imposing a copayment, coinsurance, or deductible for services provided in accordance with the Collaborative Care Model (CoCM) statewide in primary care settings that provide health care services to Program recipients.

POSITION AND RATIONALE

The Maryland Health Care Commission (MHCC) supports *SB 428* as it represents an important step towards improving quality, accessibility, and coordination of care for Marylanders. Eliminating cost sharing for services delivered through the CoCM advances an evidence-based approach to managing chronic and complex physical and behavioral health conditions. Integrating behavioral health in primary care settings reduces longstanding barriers to treatment and helps narrow disparities in health outcomes. It also expands access to care, especially in underserved communities.

The CoCM brings together primary care and behavioral health providers as a coordinated team within a patient-centered framework.[1] It reinforces collaboration among care team members (e.g., primary care providers, psychiatric consultants, behavioral health care managers) to support patients and monitor their progress. Since 2017, the Centers for

[1] Bauer MS, Weaver K, Kim B, et al. The Collaborative Chronic Care Model for Mental Health Conditions: From Evidence Synthesis to Policy Impact to Scale-up and Spread. *Med Care*. 2019; Sep 13;57(10 Suppl 3):S221-S227. doi: 10.1097/MLR.0000000000001145.

Medicare & Medicaid Services (CMS) has reimbursed for CoCM services. Even so, cost sharing remains a leading barrier to adoption of CoCM by practices as it discourages patient participation.[2] Because patients often view modest out-of-pocket costs as burdensome, they may end up avoiding or declining services. While not explicitly labeled as concierge medicine, cost sharing mirrors a pay-to-play approach, creating a financial barrier to care that disproportionately affects low income and vulnerable populations.[3]

The evidence supporting CoCM is extensive and well documented with the landmark clinical trial, "Improving Mood-Promoting Access to Collaborative Treatment" (IMPACT).[4] The two-year study followed 1,801 older adults with depression, drawing participants from 18 primary care clinics across five states. The results were striking, after 12 months, nearly half of patients in the CoCM saw their symptoms decrease by at least 50 percent, compared with just 19 percent receiving usual care. The benefit of CoCM persisted among IMPACT patients who experienced more than 100 additional depression free days. The CoCM has been successfully adapted for children, trauma survivors, individuals with substance use disorders, and those in need of behavioral health support, demonstrating its versatility across diverse populations and clinical settings.[5]

Moreover, *SB 428* aligns with federal efforts to strengthen primary care and reduce cost sharing for patients. In the 2026 Medicare Physician Fee Schedule, CMS established new, optional add-on codes to facilitate the integration of behavioral health in primary care when providing Advanced Primary Care Management (APCM) services.[6] CMS also requested comments on whether the new codes should be treated as preventive services, a designation that would authorize the elimination of cost sharing altogether. *SB 428* supports team-based care aimed at mitigating long-term risks and managing complex needs proactively. Removing cost sharing is also consistent with the principles of value-based care, which emphasize removing financial barriers to high value services.[7]

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[2] Carlo AD, Drake L, Ratzliff ADH, Chang D, Unützer J. Sustaining the Collaborative Care Model (CoCM): Billing Newly Available CoCM CPT Codes in an Academic Primary Care System. *Psychiatr Serv*. 2020;71(9) :972-974. doi: 10.1176/appi.ps.201900581.
[3] Kaiser Health News, The Concierge Catch: Better Access for a Few Patients Disrupts Care for Many. *Kaiser Health News*. July 2024. https://kffhealthnews.org/news/article/concierge-medicine-primary-care-doctor-pay-to-play/#:~:text=Email%20Sign%2DUp,harder%20to%20find%20a%20doctor. Accessed February 5, 2026.
[4] Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836.
[5] Reist C, Petiwala I, Latimer J, et al. Collaborative mental health care: A narrative review." *Medicine (Baltimore)*. 2022;101(52):e32554. doi: 10.1097/MD.0000000000032554.
[6] American Medical Association. *2026 Medicare Physician Payment Schedule and Quality Payment Program Final Rule, Summary and Analysis*." https://www.ama-assn.org/system/files/2026-mpfs-final-rule-summary-analysis.pdf. Accessed February 5, 2026.
[7] American College of Physicians, *Summary of 2026* Finalized Changes to the Medicare Physician Fee Schedule, Medicare Shared Savings Program, Quality Payment Program, and other Federal Programs. October 2025. https://www.acponline.org/sites/default/files/documents/advocacy/where_we_stand/assets/acp_summary_of_2026_physician_fee_schedule_medicare_final_rule_2025.pdf. Accessed February 5, 2026.

It is for these reasons that the MHCC recommended payers cover CoCM services without cost sharing in the 2025 *Primary Care Investment Analysis and Recommendations Report*. The annual report includes an analysis of primary care and recommendations informed by a stakeholder workgroup on the level of primary care investment relative to overall health care spending as required by Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup* (2022).[8]

When patients view the CoCM services as a standard part of primary care rather than services that require extra payment, it strengthens confidence in their care plan and encourages clinicians to participate in the model. By eliminating cost sharing, *SB 428* helps to ensure that the CoCM is viewed as an essential mainstream component of primary care. For these reasons, MHCC respectfully requests a favorable report.

[8] Md. Laws Ch. 667 (2022) The law requires MHCC to form a multi-stakeholder workgroup to provide input on the analysis and recommendations and submit a report to the Governor and the General Assembly annually by December 1st. The MHCC established the Primary Care Investment Workgroup (PCIW), which includes primary care clinicians, payers, legislators, and other State agencies, and has published two annual reports.

2026 Session - MHCC - SB 428_Collaborative Care Mo
Uploaded by: Douglas Jacobs
Position: FAV

MARYLAND
Health Care
Commission

Marcia Boyle, MS, Acting Chair
Douglas Jacobs, MD, MPH, Executive Director

2026 SESSION
POSITION PAPER

BILL NUMBER: **SB 428**

COMMITTEE: **Finance**

POSITION: **Support**

TITLE: **Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition**

BILL ANALYSIS

SB 428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition prohibits the Maryland Department of Health and certain payers from imposing a copayment, coinsurance, or deductible for services provided in accordance with the Collaborative Care Model (CoCM) statewide in primary care settings that provide health care services to Program recipients.

POSITION AND RATIONALE

The Maryland Health Care Commission (MHCC) supports *SB 428* as it represents an important step towards improving quality, accessibility, and coordination of care for Marylanders. Eliminating cost sharing for services delivered through the CoCM advances an evidence-based approach to managing chronic and complex physical and behavioral health conditions. Integrating behavioral health in primary care settings reduces longstanding barriers to treatment and helps narrow disparities in health outcomes. It also expands access to care, especially in underserved communities.

The CoCM brings together primary care and behavioral health providers as a coordinated team within a patient-centered framework.[1] It reinforces collaboration among care team members (e.g., primary care providers, psychiatric consultants, behavioral health care managers) to support patients and monitor their progress. Since 2017, the Centers for

[1] Bauer MS, Weaver K, Kim B, et al. The Collaborative Chronic Care Model for Mental Health Conditions: From Evidence Synthesis to Policy Impact to Scale-up and Spread. *Med Care*. 2019; Sep 13;57(10 Suppl 3):S221-S227. doi: 10.1097/MLR.0000000000001145.

Medicare & Medicaid Services (CMS) has reimbursed for CoCM services. Even so, cost sharing remains a leading barrier to adoption of CoCM by practices as it discourages patient participation.[2] Because patients often view modest out-of-pocket costs as burdensome, they may end up avoiding or declining services. While not explicitly labeled as concierge medicine, cost sharing mirrors a pay-to-play approach, creating a financial barrier to care that disproportionately affects low income and vulnerable populations.[3]

The evidence supporting CoCM is extensive and well documented with the landmark clinical trial, "Improving Mood-Promoting Access to Collaborative Treatment" (IMPACT).[4] The two-year study followed 1,801 older adults with depression, drawing participants from 18 primary care clinics across five states. The results were striking, after 12 months, nearly half of patients in the CoCM saw their symptoms decrease by at least 50 percent, compared with just 19 percent receiving usual care. The benefit of CoCM persisted among IMPACT patients who experienced more than 100 additional depression free days. The CoCM has been successfully adapted for children, trauma survivors, individuals with substance use disorders, and those in need of behavioral health support, demonstrating its versatility across diverse populations and clinical settings.[5]

Moreover, *SB 428* aligns with federal efforts to strengthen primary care and reduce cost sharing for patients. In the 2026 Medicare Physician Fee Schedule, CMS established new, optional add-on codes to facilitate the integration of behavioral health in primary care when providing Advanced Primary Care Management (APCM) services.[6] CMS also requested comments on whether the new codes should be treated as preventive services, a designation that would authorize the elimination of cost sharing altogether. *SB 428* supports team-based care aimed at mitigating long-term risks and managing complex needs proactively. Removing cost sharing is also consistent with the principles of value-based care, which emphasize removing financial barriers to high value services.[7]

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[3] Kaiser Health News, The Concierge Catch: Better Access for a Few Patients Disrupts Care for Many. *Kaiser Health News*. July 2024. https://kffhealthnews.org/news/article/concierge-medicine-primary-care-doctor-pay-to-play/#:~:text=Email%20Sign%2DUp,harder%20to%20find%20a%20doctor. Accessed February 5, 2026.
[4] Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836.
[5] Reist C, Petiwala I, Latimer J, et al. Collaborative mental health care: A narrative review." *Medicine (Baltimore)*. 2022;101(52):e32554. doi: 10.1097/MD.0000000000032554.
[6] American Medical Association. *2026 Medicare Physician Payment Schedule and Quality Payment Program Final Rule, Summary and Analysis*." https://www.ama-assn.org/system/files/2026-mpfs-final-rule-summary-analysis.pdf. Accessed February 5, 2026.
[7] American College of Physicians, *Summary of 2026* Finalized Changes to the Medicare Physician Fee Schedule, Medicare Shared Savings Program, Quality Payment Program, and other Federal Programs. October 2025. https://www.acponline.org/sites/default/files/documents/advocacy/where_we_stand/assets/acp_summary_of_2026_physician_fee_schedule_medicare_final_rule_2025.pdf. Accessed February 5, 2026.

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When patients view the CoCM services as a standard part of primary care rather than services that require extra payment, it strengthens confidence in their care plan and encourages clinicians to participate in the model. By eliminating cost sharing, *SB 428* helps to ensure that the CoCM is viewed as an essential mainstream component of primary care. For these reasons, MHCC respectfully requests a favorable report.

[8] Md. Laws Ch. 667 (2022) The law requires MHCC to form a multi-stakeholder workgroup to provide input on the analysis and recommendations and submit a report to the Governor and the General Assembly annually by December 1st. The MHCC established the Primary Care Investment Workgroup (PCIW), which includes primary care clinicians, payers, legislators, and other State agencies, and has published two annual reports.

testimony SB 428 Collab Care cost sharing MDDCSAM

Uploaded by: Joseph Adams, MD

Position: FAV

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 428 SUPPORT

Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition

Senate Finance Committee February 18, 2026

Unfortunately, existing cost sharing requirements for collaborative services undermine the program's effectiveness. With cost sharing in place, patients are typically not returning for follow-up visits. Patients in need of these services are particularly likely to be experiencing financial challenges.

Mental health and substance use disorders cannot be effectively treated with a single visit. Follow-up visits are crucial.

Most mental health and substance use disorders are recognized and treated in the primary care setting, where treatment is less effective than that provided by specialists. Primary care providers can quickly learn best practices from specialists through collaborating in the care of existing patients. **This is an efficient way to extend the reach of specialists, reducing barriers to treatment. The skill and interest of the primary care provider improves as well.**

Many patients who are unable to complete a referral to a specialist can conveniently access co-located care.

The acute shortage of buprenorphine prescribers can be addressed with collaborative care, helping primary care providers become more comfortable and willing to become buprenorphine prescribers, the lack of which limits our ability to address opioid addiction and overdose deaths.

Mental health and substance use disorders are known to be major drivers of healthcare costs; they are strongly association with chronic somatic disease.

As a former primary care physician, I can attest that we work primarily in isolation. Primary care providers want to learn more about these disorders. There is no a substitute for case-based learning from a specialist.

Respectfully,
Joseph Adams, MD, FASAM, addiction medicine, internal medicine;
Co-Chair, MDDCSAM Public Policy Committe

Shatterproof Testimony SB 428_HB746 (Feb 2026).pdf
Uploaded by: Kevin Roy
Position: FAV

February 15, 2026

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Delegate Heather Bagnall, Chair
Delegate Bonnie Cullison, Vice Chair
House Health Committee
241 Taylor House Office Building
Annapolis, Maryland 21401

RE: Support for SB0428 and HB 0746

Dear Chair Beidle and Vice Chair Hayes and Chair Bagnall and Vice Chair Cullison:

I am providing testimony on behalf of Shatterproof in support of Senate Bill 0428 and House Bill 0746, legislation to prohibit the Maryland Department of Health and certain carriers from imposing a copay, coinsurance, or deductible for services provided in accordance with the Collaborative Care Model statewide in primary care settings.

Shatterproof is a national nonprofit dedicated to a world where addiction never defines or ends a life.

Senate Bill 0428 and House Bill 0746 would eliminate out of pocket costs to access the Collaborative Care Model, an evidence-based model to integrate mental health and substance use care into the primary care setting.

The Collaborative Care Model is a well-studied treatment model for the primary care setting that has been shown in more than 80 randomized controlled trials to improve outcomes, be cost-effective, and ameliorate racial and other disparities in health outcomes.

The model relies on universal screening for behavioral health conditions, measurement-based care, and a three-person care team consisting of a primary care physician, a care manager, and a psychiatrist or addiction specialist. The Centers for Medicare and Medicaid Services created Medicaid codes for the model in 2017, and to date, 35 states and many private payers cover the model.

It is estimated that 50 percent of individuals with a mental health disorder have a comorbid substance use disorder. The SUMMIT Randomized Clinical Trial found that collaborative care for opioid and alcohol use disorder increased both the proportion of patients receiving evidence-based treatment and the number achieving abstinence at six months. Abstinence improved 47% over the control[1].

[1] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2652574

In addition to the health benefits of collaborative care, the model is one of the very few interventions in medicine that have been shown to reduce disparities by race/ethnicity and/or socioeconomic status in patients' access to care, quality of care, and outcomes. Furthermore, as healthcare workforce challenges continue unabated, the Collaborative Care Model leverages primary care, case management, and psychiatric professionals to maximize the existing workforce to address patient needs.

Around the country, Medicaid enrollees with behavioral health conditions, including substance use disorders, account for approximately 20 percent of enrollees, but over half of Medicaid spending. Several studies have demonstrated that the Collaborative Care Model is cost-effective. Findings from the IMPACT study observed that the model was associated with substantially lower total healthcare costs compared to typical care – a return on investment of $6.50 for every $1 invested[2].

Shatterproof encourages the passage of Bill 0428 and House Bill 0746 to reduce the potential barrier of co-pays to access the Collaborative Care Model. This policy change will help improve access to SUD care in Maryland and enhance the state's commitment to quality behavioral health care.

Sincerely,

Kevin Roy

Kevin Roy
Chief Public Policy Officer
Shatterproof

CC:
Senator Augustine
Delegate Bagnall

[2] https://www.ajmc.com/view/feb08-2835p095-100

Children's National Testimony - SB 428 - Laura Wil
Uploaded by: Laura Willing
Position: FAV

111 Michigan Ave NW
Washington, DC 20010-2916
ChildrensNational.org

Testimony of Laura Willing, MD, MEd
Medical Director for Mental Health Policy and Advocacy, Community Mental Health CORE
Children's National Hospital
Department of Psychiatry & Behavioral Sciences

SB 428: Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition
Position: FAVORABLE
February 18, 2026
Senate Finance Committee

Chair Beidle, Vice Chair Hayes and members of the committee, thank you for the opportunity to provide written testimony in support of Senate Bill 428. My name is Laura Willing, and I am a child and adolescent psychiatrist and the Medical Director for Mental Health Policy and Advocacy for the Community Mental Health CORE at Children's National Hospital. As the region's only standalone children's hospital, Children's National has been serving the nation's children since 1870. For 155 years, we have delivered expert pediatric care at every milestone. Sixty percent of our patients are residents of Maryland, and we maintain a large network of community-based pediatric practices, surgery centers and regional outpatient centers in Maryland.

The goal of this bill is to increase access to and utilization of the Collaborative Care Model so that Marylanders are able to access quality mental health care integrated into the primary care setting. The Collaborative Care Model is an evidence-based model that includes a primary care physician, such as a pediatrician, a behavioral health care manager, such as a social worker, and a psychiatric consultant, such as a psychiatrist or child psychiatrist. In this model, the pediatrician diagnoses, treats, and manages the care of the patient with the support of the psychiatric consultant and the behavioral health care manager. In this way, patients with common conditions, such as mild to moderate Depression, Anxiety, and ADHD, can receive quality, accessible care in the primary care office. The psychiatric consultant supports the pediatrician is taking care of an entire panel of patients, which significantly increases access to mental health care. The behavioral health care manager is also able to support the patient in accessing additional appropriate services, such as individual therapy, and providing brief interventions in the primary care setting to address symptoms.

Multiple studies have shown that the Collaborative Care Model improves mental health and physical health outcomes, and reduces costs in the healthcare system.[1],[2],[3],[4],[5] In youth, multiple studies have found that the Collaborative Care Model is useful for treating ADHD, Depression, and Anxiety disorders.[6],[7],[8] In fact, the Collaborative Care Model was identified in the Maryland Health Care Commission 2024 behavioral health workforce report as a key strategy for addressing Maryland's workforce challenges.[9]

A recent report by the Bowman Family Foundation describes that the Collaborative Care Model is showing rapid growth nationally, especially for children and adolescents.[10] However, the report describes that patient cost-sharing, such as requiring a copay, coinsurance, or deductible reduced use of the Collaborative Care Model. For example, in Michigan, 55% of commercially insured patients initially declined to continue in the collaborative care model after they received their first bill for cost sharing.[11]

Given that Maryland is facing a work force shortage of mental health professionals, that patients struggle to find in-network mental health care,[12] and that there is an ongoing pediatric mental health crisis, we should be doing everything we can to improve access to quality mental healthcare for all Marylanders.

I applaud Senator Augustine for introducing this important legislation, which will have life-long benefits for our state's youngest residents and their families and respectfully request a favorable report on Senate Bill 428. Thank you for the opportunity to submit testimony.

For more information, please contact:
Austin Morris, Government Affairs Manager
almorris@childrensnational.org

[1] Unützer, J., Katon, W., Callahan, C. M., Williams, Jr, J. W., Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H. B., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., Langston, C., & for the IMPACT Investigators. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting. JAMA, 288(22), 2836. https://doi.org/10.1001/jama.288.22.2836.

[2] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. The Cochrane Database of Systematic Reviews, 10(10), CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

[3] Katon, W. J., Lin, E. H. B., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., Peterson, D., Rutter, C. M., McGregor, M., & McCulloch, D. (2010). Collaborative Care for Patients with Depression and Chronic Illnesses. New England Journal of Medicine, 363(27), 26112620. https://doi.org/10.1056/NEJMoa1003955

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[5] Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018). Potential economic impact of integrated medical-behavioral healthcare. Milliman: Seattle, WA, USA.

[6] Yonek, J., Lee, C. M., Harrison, A., Mangurian, C., & Tolou-Shams, M. (2020). Key Components of Effective Pediatric Integrated Mental Health Care Models: A Systematic Review. JAMA Pediatrics, 174(5), 487–498. https://doi.org/10.1001/jamapediatrics.2020.0023

[7] Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care: A randomized clinical trial. JAMA - Journal of the American Medical Association, 312(8), 809–816. https://doi.org/10.1001/jama.2014.9259

[8] Silverstein, M., Hironaka, L. K., Walter, H. J., Feinberg, E., Sandler, J., Pellicer, M., Chen, N., & Cabral, H. (2015). Collaborative care for children with ADHD symptoms: A randomized comparative effectiveness trial. Pediatrics, 135(4), e858–e867. https://doi.org/10.1542/peds.2014-3221

[9] Maryland Health Care Commission. Investing in Maryland's Behavioral Health Talent. October, 2024. https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/md_bh_workforce_rpt_SB283.pdf

[10] Progress Report: Psychiatric Collaborative Care Model. The Bowman Family Foundation and the Mental Health Treatment and Research Institute. February, 2026. https://filesmhtari.org/COCM_Progress_Report.pdf

[11] Richmond LM. Payors Train PCPs to Treat Mental Health in House. Psych News 2021; 56 https://doi.org/10.1176/appi.pn.2021.11.4

[12] Melek S, Gray T, Davenport S. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman. Published November 19, 2019. https://assets.milliman.com/ektron/Addiction_and_mental_ health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

SB 428 - FAV.pdf
Uploaded by: Megan Peters
Position: FAV

Maryland Senior Citizens Action Network

MSCAN

AARP Maryland

Baltimore Jewish Council

Catholic Charities of Baltimore

Central Maryland Ecumenical Council

Church of the Brethren

Episcopal Diocese of Maryland

Housing Opportunities Commission of Montgomery County

Lutheran Office on Public Policy in Maryland

Maryland Association of Area Agencies on Aging

Maryland Catholic Conference

Mental Health Association of Maryland

Mid-Atlantic LifeSpan

National Association of Social Workers, Maryland Chapter

Presbytery of Baltimore

The Coordinating Center

MSCAN Co-Chairs:
Carol Lienhard
Megan Peters
410-921-9005

The Maryland Senior Citizens Action Network (MSCAN) is a statewide coalition of advocacy groups, service providers, faith-based and mission-driven organizations that support policies that meet the housing, health, and quality of care needs of Maryland's low and moderate-income seniors.

MSCAN supports SB 428. This bill will ensure that Marylanders receiving integrated behavioral health care through the Collaborative Care Model do not have to pay out-of-pocket costs. It removes financial barriers to getting behavioral health conditions identified and treated in primary care settings.

More than 50% of older adults with behavioral health conditions do not receive treatment. Stigma, cost, and transportation challenges are barriers to accessing specialty behavioral health care, especially for older adults. To address this gap, mild to moderate behavioral health conditions can and should be identified and treated in primary care settings.

The Collaborative Care Model is an evidence-based approach to integrating behavioral and physical healthcare, enabling older adults to receive screening, treatment, and ongoing monitoring in the familiar setting of their primary care. For many older adults managing multiple chronic illnesses, mobility limitations, or social isolation, this integrated model is the difference between untreated behavioral health needs and early, effective intervention. Eliminating cost-sharing helps ensure that behavioral health is treated like any other essential component care, particularly important for older adults who frequently live on fixed incomes.

For these reasons, MSCAN urges a favorable report for SB 428.

SB428 - FAV - NAMI.pdf
Uploaded by: Michael Gray
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

February 18, 2026

Chair Beidle, Vice Chair Hayes, and distinguished members of the Finance Committee,

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 60,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community.

NAMI Maryland recognizes that physical and mental health symptoms and conditions are often related and intertwined in ways that necessitate the treatment of mental health conditions in primary or specialty care settings. The statewide shortage of mental healthcare providers also means that primary care and similar providers are the only hope for many Marylanders living with mental health conditions. People living in rural areas and underserved urban areas are especially at risk of having little access to psychiatry and other mental health services. For those reasons, NAMI Maryland supports our state's Collaborative Care Model (CoCM) and supports the effect of SB428—to lower a significant barrier of care by making mental health services more affordable and accessible.

SB428 makes services provided under the CoCM more affordable by eliminating copays, coinsurance, or deductible for services provided to Medicaid enrollees. People who are Medicaid eligible and living with mental health conditions are among the most vulnerable people in our state and any copay or other financial imposition can be an insurmountable barrier to them accessing the care they need, when they need it.

This bill is an important step towards addressing the lack of mental healthcare providers in Maryland and recognizing the important role of primary care providers in a statewide continuum of care.

For these reasons, we urge a favorable report on SB428.

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

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

Maryland Catholic Conference_FAVSB428_.pdf
Uploaded by: Michelle Zelaya
Position: FAV

MARYLAND CATHOLIC CONFERENCE

February 18th 2026
SB428
Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition
Finance Committee
Position: Favorable

The Maryland Catholic Conference offers this testimony in support of **Senate Bill 428.** The Maryland Catholic Conference is the public policy representative of the three (arch)dioceses serving Maryland, which together encompass over one million Marylanders. Statewide, their parishes, schools, hospitals and numerous charities combine to form our state's second largest social service provider network, behind only our state government.

Senate Bill 428 prohibits the Maryland Department of Health and certain insurance carriers from imposing copays, coinsurance, or deductibles for services provided under the Collaborative Care Model in primary care settings that serve Medicaid recipients. The Collaborative Care Model integrates mental and behavioral health care into primary care, ensuring that Marylanders receive timely, coordinated, and comprehensive treatment without financial barriers. By removing cost-sharing requirements, the bill ensures that those who rely on the Maryland Medical Assistance Program have equitable access to essential care.

This legislation would bring tremendous benefit to the State of Maryland by reducing long-term health costs, improving patient outcomes, and helping to close persistent health disparities. Communities would experience stronger support systems as more individuals receive the mental health and behavioral health services they need to function well at home, at work, and in society. Families would see improved stability as untreated mental health conditions—often left unaddressed due to cost—are treated earlier and more effectively. For individual Marylanders, especially those in low-income communities, eliminating copays and deductibles removes the greatest barrier to receiving life-changing care. It affirms that health access is not a privilege based on financial means but a public good that strengthens the whole state.

Senate Bill 428 aligns with the principles of human dignity, solidarity, and the preferential option for the poor. The Church teaches that every person deserves access to the care necessary for their physical and mental well-being, particularly the most vulnerable among us. Mental health care supports the whole person and allows individuals to fully participate in family life and their communities. By ensuring financial barriers do not prevent access to essential behavioral health services, this legislation upholds the dignity of every person and reflects our shared moral duty to care for one another with compassion and justice.

For these reasons, the Maryland Catholic Conference urges a favorable report on **Senate Bill 428.**

NCADD-MD - 2026 SB 428 FAV - Collaborative Care Mo
Uploaded by: Nancy Rosen-Cohen
Position: FAV

Senate Finance Committee
February 18, 2026

Senate Bill 428
Maryland Medical Assistance Program and Health Insurance –
Collaborative Care Model - Cost Sharing Prohibition
Support

NCADD-Maryland supports Senate Bill 428, a bill to prohibit Medicaid and commercial insurance carriers from imposing a copay, coinsurance, or deductible for behavioral health services provided via the Collaborative Care Model (CoCM). This validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings has been validated in over 90 randomized controlled trials and shown to improve health outcomes and reduce costs[i].

Increasing the use of CoCM across Maryland is vital, but data shows a drop-off of CoCM billing after a patient's first visit. This totally defeats the benefit of the model. The decline in billing after the initial appointment is being attributed to a reluctance among patients to pay additional out of pocket costs for the important follow-up visits.

Senate Bill 428 would eliminate those out-of-pocket costs, a strategy that is a key recommendation in a brand new CoCM national report[ii] issued last week. We know that removing utilization management barriers is important, especially for people seeking help with their mental health and substance use disorders. NCADD-Maryland urges this committee to give a favorable report to Senate Bill 428.

[i] https://concerthealth.com/blog/new-report-collaborative-care-reduces-costs
[ii] https://filesmhtari.org/COCM_Progress_Report.pdf

SB0428-CBH-FAV.pdf
Uploaded by: Nicole Graner
Position: FAV

SB428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition
Senate Finance Committee
February 18, 2026

POSITION: SUPPORT

My name is Nicole Graner and I am the Director of Government Affairs and Public Policy for the Community Behavioral Health Association of Maryland. I am pleased to submit written testimony in support of Senate Bill 428.

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 95 members serve the majority of individuals who access care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

Senate Bill 428 prohibits Medicaid and commercial carriers from imposing a copay, coinsurance, or deductible for behavioral health services provided through the Collaborative Care Model (CoCM).

CoCM is a validated, patient-centered, evidence-based approach for integrating physical and behavioral health care in primary care settings. The model has been validated in over 90 randomized controlled trials and has been shown to improve health outcomes and reduce costs.

Maryland continues to face behavioral health workforce challenges. A 2024 report from the Maryland Health Care Commission found that the state would need to double its current behavioral health workforce by 2028 to keep pace with demand. CoCM is recognized as an important long-term strategy for addressing these challenges — particularly in rural areas — because it expands the reach of the existing workforce, allowing providers to treat up to eight times the number of patients compared to traditional one-to-one care.

Increasing the use of CoCM is important; however, state partners report a drop-off in billing after a patient's first visit, which undermines the benefit of the model. This decline is being attributed to patient reluctance to pay additional out-of-pocket costs for follow-up visits. Eliminating those costs is a key recommendation in a timely new national CoCM report and may help support continued engagement in care.

Reducing financial barriers to evidence-based models of care supports broader access to behavioral health services. For these reasons, CBH respectfully requests a favorable report on SB428.

For more information contact Nicole Graner, Director of Government Affairs and Public Policy, at Nicole@mdcbh.org.

sb428.docx (1).pdf
Uploaded by: priyanka fernandes
Position: FAV

Statement of Maryland Rural Health Association

To the Senate Finance Committee
Chair Pamela Beidle
February 12, 2026
Senate Bill 428: Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition.

POSITION: SUPPORT

Chair Beidle, Vice Chair Hayes, Senator Augustine and members of the Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 428: Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition.

The MRHA strongly supports this bill which seeks to prohibit insurance companies from charging a copay or deductible for those using health services through the Collaborative Care Model. This model was designed in a patient-centered and evidence-based fashion aimed at helping patients struggling with depression and anxiety (1). The Collaborative Care Model is unique in that it connects patients with medical providers, psychiatric consultants, and care managers in a primary care setting and consistently outperforms other standard of care frameworks (1). The American Psychiatric Association notes that this approach not only increases mental health access and improves patient outcomes, but also limits the cost to the patient and makes it more affordable to receive care (2)

Those living in rural communities have higher rates of uninsurance and cite financial barriers to care more often than those living in urban centers (3). Additionally, rural residents have increased stigma surrounding mental health and experience behavioral health provider shortages leading to gaps in care (4). The American Psychiatric Association shares that both rural and urban communities have voiced appreciation for this care model, as it works in a patient-centered fashion to reduce barriers to care (2).

Understanding that this bill has the opportunity to improve mental health care and access for all Maryland residents, especially those living in rural communities, the MRHA deeply encourages your support of Senate Bill 428.

With appreciation,

The Maryland Rural Health Association

1. Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. *Medicine*, *101*(52), e32554.
2. American Psychiatric Association "Learn About the Collaborative Care Model"
3. Gong, Gordon et al. "Higher US Rural Mortality Rates Linked To Socioeconomic Status, Physician Shortages, And Lack Of Health Insurance." *Health affairs (Project Hope)* vol. 38,12 (2019): 2003-2010.
4. Pieh-Holder, K L et al. "Qualitative needs assessment: healthcare experiences of underserved populations in Montgomery County, Virginia, USA." *Rural and remote health* vol. 12 (2012): 1816.

P.O. Box 3128 LaVale, MD 21504

Testimony in support of SB0428 - Collaborative Car
Uploaded by: Richard KAP Kaplowitz
Position: FAV

SB0428_RichardKaplowitz_FAV
02/18/2026
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON SB#0428 POSITION: FAVORABLE

Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition

TO: Chair Beidle, Vice Chair Hayes, and members of the Finance Committee
FROM: Richard Keith Kaplowitz

My name is Richard Keith Kaplowitz. I am a resident of District 3, Frederick County. I am submitting this testimony in support of SB#/0428, **Maryland Medical Assistance Program and Health Insurance - Collaborative Care Model - Cost Sharing Prohibition**

The National Library of Medicine has a report *Collaborative mental health care: A narrative review* that explains what the collaborative care model is. [1]

> The Collaborative Care model is a systematic strategy for treating behavioral health conditions in primary care through the integration of care managers and psychiatric consultants.

This bill adds prohibitions on the financial penalties that sometime are accessed on patients when mental health services are being provided. It treats that medical service as no different from other medical treatments being implemented for a patient.

The bill will prohibit the Maryland Department of Health and certain carriers from imposing a copay, coinsurance, or deductible for services provided in accordance with the Collaborative Care Model statewide in primary care settings that provide health care services to Program recipients.

No one should fail to receive the care they need because of costs added to use of that treatment.

I respectfully urge this committee to return a favorable report on SB#/0428.

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC9803502/

SB 428 - Collaborative Care - FAV - AARP MD.pdf
Uploaded by: Sara Westrick
Position: FAV

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SB 428 - Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition
Senate Finance Committee
February 18, 2026
FAVORABLE

Chair Beidle, Vice Chair Hayes, and members of the Senate Finance Committee, thank you for the opportunity to submit written testimony in support of Senate Bill 428. On behalf of AARP Maryland and our 850,000 members across the state, I urge the committee to pass Senate Bill 428 regarding the Collaborative Care Model Cost Sharing Prohibition. We thank Senator Augustine for sponsoring this important legislation.

My name is Dr. Lois Meszaros, and I am a licensed psychologist with a clinical practice in Anne Arundel County. As a mental health care provider, I am encouraged to see this bill as a vital step forward in meeting the mental and behavioral health needs of older Marylanders, particularly adults age 50 and older who rely on their primary care providers as their main—and often only—source of mental health care.

For many older adults, primary care is the front door to the health care system. It is where depression, anxiety, grief, cognitive changes, substance use concerns, and chronic-disease-related behavioral health needs are first identified. Yet despite the prevalence of these conditions, older adults frequently encounter significant barriers when trying to access mental health services, including high out-of-pocket costs and a fragmented system that requires them to seek care outside the familiar setting of their primary care practice.

SB 428 directly addresses these barriers by prohibiting copays, coinsurance, and deductibles for services delivered under the Collaborative Care Model (CoCM) in both the Maryland Medical Assistance Program and commercial insurance plans. For adults over 50, this change will make a meaningful difference. It ensures that mental health care delivered in the primary care setting is truly accessible, affordable, and integrated.

The Collaborative Care Model is proven to enhance outcomes, increase early identification of behavioral health needs, and reduce the stigma often associated with seeking mental health treatment. When implemented in primary care, CoCM allows older patients to receive coordinated support from a care manager, consulting psychiatric specialists, and their trusted primary care provider. This team-based approach is especially critical for older adults, who may be more comfortable receiving sensitive behavioral health support from providers they already know.

Unfortunately, cost-sharing requirements routinely discourage older adults from following through with treatment. Even modest copays can become insurmountable for individuals on limited incomes, leading them to delay or abandon needed care. SB 428 removes these financial obstacles and ensures that cost is never a reason a patient forgoes mental health treatment offered in the primary care setting.

By eliminating cost-sharing across Medicaid and commercial insurance, SB 428 creates consistency, expands access, and supports early intervention, reducing long-term costs to the health care system while improving quality of life for thousands of older Marylanders.

This legislation will strengthen Maryland's behavioral health system, promote equity for older adults, and ensure that primary care-based mental health services are within reach for everyone who needs them.

For these reasons, AARP Maryland respectfully urges a **favorable report** on Senate Bill 428. Thank you for your consideration and your commitment to the health of Maryland's aging population.

If you have any questions, please contact Sara Westrick at swestrick@aarp.org or 410-310-0374.

SB 428 - FIN - MHCC- LOS (Final 2-18-2026).pdf
Uploaded by: State of Maryland (MD)
Position: FAV

MARYLAND
Health Care
Commission

Marcia Boyle, MS, Acting Chair
Douglas Jacobs, MD, MPH, Executive Director

2026 SESSION
POSITION PAPER

BILL NUMBER: **SB 428**

COMMITTEE: **Finance**

POSITION: **Support**

TITLE: **Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition**

BILL ANALYSIS

SB 428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition prohibits the Maryland Department of Health and certain payers from imposing a copayment, coinsurance, or deductible for services provided in accordance with the Collaborative Care Model (CoCM) statewide in primary care settings that provide health care services to Program recipients.

POSITION AND RATIONALE

The Maryland Health Care Commission (MHCC) supports *SB 428* as it represents an important step towards improving quality, accessibility, and coordination of care for Marylanders. Eliminating cost sharing for services delivered through the CoCM advances an evidence-based approach to managing chronic and complex physical and behavioral health conditions. Integrating behavioral health in primary care settings reduces longstanding barriers to treatment and helps narrow disparities in health outcomes. It also expands access to care, especially in underserved communities.

The CoCM brings together primary care and behavioral health providers as a coordinated team within a patient-centered framework.[1] It reinforces collaboration among care team members (e.g., primary care providers, psychiatric consultants, behavioral health care managers) to support patients and monitor their progress. Since 2017, the Centers for

[1] Bauer MS, Weaver K, Kim B, et al. The Collaborative Chronic Care Model for Mental Health Conditions: From Evidence Synthesis to Policy Impact to Scale-up and Spread. *Med Care*. 2019; Sep 13;57(10 Suppl 3):S221-S227. doi: 10.1097/MLR.0000000000001145.

Medicare & Medicaid Services (CMS) has reimbursed for CoCM services. Even so, cost sharing remains a leading barrier to adoption of CoCM by practices as it discourages patient participation.[2] Because patients often view modest out-of-pocket costs as burdensome, they may end up avoiding or declining services. While not explicitly labeled as concierge medicine, cost sharing mirrors a pay-to-play approach, creating a financial barrier to care that disproportionately affects low income and vulnerable populations.[3]

The evidence supporting CoCM is extensive and well documented with the landmark clinical trial, "Improving Mood-Promoting Access to Collaborative Treatment" (IMPACT).[4] The two-year study followed 1,801 older adults with depression, drawing participants from 18 primary care clinics across five states. The results were striking, after 12 months, nearly half of patients in the CoCM saw their symptoms decrease by at least 50 percent, compared with just 19 percent receiving usual care. The benefit of CoCM persisted among IMPACT patients who experienced more than 100 additional depression free days. The CoCM has been successfully adapted for children, trauma survivors, individuals with substance use disorders, and those in need of behavioral health support, demonstrating its versatility across diverse populations and clinical settings.[5]

Moreover, *SB 428* aligns with federal efforts to strengthen primary care and reduce cost sharing for patients. In the 2026 Medicare Physician Fee Schedule, CMS established new, optional add-on codes to facilitate the integration of behavioral health in primary care when providing Advanced Primary Care Management (APCM) services.[6] CMS also requested comments on whether the new codes should be treated as preventive services, a designation that would authorize the elimination of cost sharing altogether. *SB 428* supports team-based care aimed at mitigating long-term risks and managing complex needs proactively. Removing cost sharing is also consistent with the principles of value-based care, which emphasize removing financial barriers to high value services.[7]

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[2] Carlo AD, Drake L, Ratzliff ADH, Chang D, Unützer J. Sustaining the Collaborative Care Model (CoCM): Billing Newly Available CoCM CPT Codes in an Academic Primary Care System. *Psychiatr Serv*. 2020;71(9) :972-974. doi: 10.1176/appi.ps.201900581.
[3] Kaiser Health News, The Concierge Catch: Better Access for a Few Patients Disrupts Care for Many. *Kaiser Health News*. July 2024. https://kffhealthnews.org/news/article/concierge-medicine-primary-care-doctor-pay-to-play/#:~:text=Email%20Sign%2DUp,harder%20to%20find%20a%20doctor. Accessed February 5, 2026.
[4] Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836–2845. doi:10.1001/jama.288.22.2836.
[5] Reist C, Petiwala I, Latimer J, et al. Collaborative mental health care: A narrative review." *Medicine (Baltimore)*. 2022;101(52):e32554. doi: 10.1097/MD.0000000000032554.
[6] American Medical Association. *2026 Medicare Physician Payment Schedule and Quality Payment Program Final Rule, Summary and Analysis*." https://www.ama-assn.org/system/files/2026-mpfs-final-rule-summary-analysis.pdf. Accessed February 5, 2026.
[7] American College of Physicians, *Summary of 2026* Finalized Changes to the Medicare Physician Fee Schedule, Medicare Shared Savings Program, Quality Payment Program, and other Federal Programs. October 2025. https://www.acponline.org/sites/default/files/documents/advocacy/where_we_stand/assets/acp_summary_of_2026_physician_fee_schedule_medicare_final_rule_2025.pdf. Accessed February 5, 2026.

It is for these reasons that the MHCC recommended payers cover CoCM services without cost sharing in the 2025 *Primary Care Investment Analysis and Recommendations Report*. The annual report includes an analysis of primary care and recommendations informed by a stakeholder workgroup on the level of primary care investment relative to overall health care spending as required by Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup* (2022).[8]

When patients view the CoCM services as a standard part of primary care rather than services that require extra payment, it strengthens confidence in their care plan and encourages clinicians to participate in the model. By eliminating cost sharing, *SB 428* helps to ensure that the CoCM is viewed as an essential mainstream component of primary care. For these reasons, MHCC respectfully requests a favorable report.

[8] Md. Laws Ch. 667 (2022) The law requires MHCC to form a multi-stakeholder workgroup to provide input on the analysis and recommendations and submit a report to the Governor and the General Assembly annually by December 1st. The MHCC established the Primary Care Investment Workgroup (PCIW), which includes primary care clinicians, payers, legislators, and other State agencies, and has published two annual reports.

SB 428 Letter - Support.pdf
Uploaded by: Taylor Dickerson
Position: FAV

MARYLAND PSYCHOLOGICAL ASSOCIATION

9175 Guilford Road, Ste 300 #1112, Columbia, MD 21046 | 410-992-4258 | www.marylandpsychology.org

February 16, 2026

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401

RE: SB 428 Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition

Position: SUPPORT

Dear Chair Beidle, Vice-Chair Hayes, and Members of the Committee:

The Maryland Psychological Association (MPA), which represents over 1,000 doctoral-level psychologists throughout the state, asks the Senate Finance Committee to **FAVORABLY report on SB 428.**

SB 428 strengthens Maryland's commitment to integrated behavioral health care by prohibiting copayments, coinsurance, and deductible requirements for services delivered under the Collaborative Care Model in primary care settings. SB 428 also reinforces the evidence-based structure of the Collaborative Care Model as defined in § 15-141.1 of the Health–General Article, which includes systematic care coordination, proactive outcome monitoring, and regular psychiatric consultation. As outlined in the bill, the Maryland Department of Health may not impose copayments, coinsurance, or deductible requirements for services provided under this model in primary care settings serving Medical Assistance recipients, and insurers and HMOs are similarly restricted under new § 15-864 of the Insurance Article

By eliminating financial barriers to integrated behavioral health treatment, SB 428 ensures that patients can access timely, coordinated mental health care without the deterrent effect of cost-sharing requirements.

The Collaborative Care Model is one of the most rigorously studied and effective approaches for treating common mental health conditions such as depression, anxiety, and substance use disorders within primary care. Removing cost-sharing barriers is particularly critical for low-income and high-need populations, who are disproportionately affected by untreated behavioral health conditions. SB 428 promotes early intervention, improves clinical outcomes, reduces downstream medical costs, and supports parity principles by placing behavioral health services within the same accessible framework as other essential medical services.

We urge the Committee to issue a **favorable report on SB 428**. If we can be of any further assistance, please do not hesitate to contact MPA's Legislative Chair, Dr. Stephanie Olate, Ph.D. at mpalegislativecommittee@gmail.com.

Respectfully submitted,

Stephanie Wolf, JD, Ph.D.
Stephanie Wolf, JD, Ph.D.
President

Stephanie Olarte, Ph.D.
Stephanie Olarte, Ph.D.
Chair, MPA Legislative Committee

cc: Barbara Brocato & Dan Shattuck, MPA Government Affairs

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Uploaded by: Matthew Celentano

Position: UNF

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

February 18, 2026

The Honorable Pam Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

Senate Bill 428 – Maryland Medical Assistance and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition

Dear Chair Beidle,

The League of Life and Health Insurers of Maryland, Inc. respectfully opposes *Senate Bill 428 – Maryland Medical Assistance and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition* and urges the committee to give the bill an unfavorable report.

The League and our members are committed to furthering progress using evidence-based practices to integrate somatic and behavioral health services in primary care settings. Although not uniform in approach, League carriers are already covering and reimbursing for the associated services outlined in SB 428. While we support the intent of this legislation and will continue to make sure Marylander's needs are met, we cannot support the prohibition on cost-sharing which takes away a key tool and fundamental mechanism to manage financial risk, manage utilization, and maintain plan affordability for Maryland consumers.

Under the ACA, each state must pay for every health plan purchased through the Maryland Health Benefit Exchange, the additional premium associated with any state-mandated benefit beyond the federally mandated essential health benefits. This means, should the Commissioner include the mandate in the State benchmark plan, the State would be required to defray the cost of the benefits to the extent it applies to the individual and small group market ACA plans.

The League opposes any additional mandated benefits to Maryland's law. Mandated benefits add cost to health insurance policies in our state and limit the ability of insurers to design benefits to best meet the needs of enrollees. Given the potential impact to health insurance costs in the State, Maryland law includes a statutory framework for review and evaluation of proposed mandated benefits by the Maryland Health Care Commission under § 15-1501 of the Insurance Article. The law requires the assessment of a proposed mandate for the social, medical and financial impact of the proposed mandate and equips the General Assembly with such information as the extent to which the service is generally utilized by a significant

portion of the population; the extent to which the insurance coverage is already generally available; if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary health care treatments; if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship; and the level of public demand for the service. Before adopting this or any other mandated health benefit, we urge the Committee first request an evaluation of the proposed benefit to facilitate an informed decision.

For these reasons, the League urges the committee to give Senate Bill 428 an unfavorable report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

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Uploaded by: Meghan Lynch
Position: INFO

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

February 18, 2026

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

RE: Senate Bill 428 – Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition – Letter of Information

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (the Department) respectfully submits this letter of information for Senate Bill (SB) 428, Maryland Medical Assistance Program and Health Insurance – Collaborative Care Model – Cost Sharing Prohibition. SB 428 prohibits the Department from imposing cost sharing on Collaborative Care Model services provided to Maryland Medical Assistance participants.

At this time, the Department does not impose any type of cost sharing for Collaborative Care Model services. Currently, the Department only applies copayments to pharmacy benefits, which are $1 for generic/preferred drugs and $3 for brand-name/non-preferred drugs.

Federal requirements will change in the future. Effective October 1, 2028, §71120 of H.R. 1, the One Big Beautiful Bill Act of 2025, requires state Medicaid programs to impose cost sharing on services provided to the Affordable Care Act (ACA) Expansion Adults. Currently approximately 320,000 Medicaid enrollees are ACA adults. Cost sharing cannot exceed $35 for any care, item, or service, and aggregate out-of-pocket costs for a family cannot exceed 5% of the family's income. Further guidance from the Centers for Medicaid Services (CMS) is needed to understand whether Maryland's existing cost-sharing requirements for pharmacy will be sufficient to satisfy this new requirement or if cost-sharing must be extended to new services, such as collaborative care.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Government Affairs at meghan.lynch@maryland.gov or (410) 260-3190.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary