Chapter 219

(House Bill 772)

AN ACT concerning

~~Workgroup on~~ Behavioral Health Rate Methodology Modernization – Workgroup Establishment and Study

FOR the purpose of requiring the Maryland Department of Health, rather than the Behavioral Health Administration and the Medical Care Programs Administration, to conduct a certain rate–setting study; requiring the Department to review and implement certain recommendations and administer certain tools and oversee certain submissions required to support a certain study; requiring the Maryland Health Care Commission to assist the Department with the facilitation of a certain study; altering the date by which the rate–setting study is to be completed; requiring the Secretary of Health, or the Secretary's designee, to designate a representative of the Administration to be a certain technical liaison; authorizing the Commission, rather than the Department, to require community providers to submit certain information for the completion of a certain report; altering certain requirements related to the submission of a certain interim report and when certain annual reports must be submitted; establishing the Workgroup on Behavioral Health Rate Methodology Modernization in the ~~Maryland Health Care~~ Commission to develop certain reimbursement methodologies for certified community behavioral health clinics ~~and~~, outpatient mental health centers, and independent outpatient providers; and generally relating to behavioral health rate methodology modernization.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 16–201.3(e) and (h)
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

16–201.3.

(e) **(1) IN THIS SUBSECTION, "COMMISSION" MEANS THE MARYLAND HEALTH CARE COMMISSION.**

[(1)**] (2) [**The Behavioral Health Administration and the Medical Care Programs Administration jointly**] ON OR BEFORE JUNE 30, 2028, THE DEPARTMENT** shall:

(i) Conduct an independent cost–driven, rate–setting study to set community provider rates for community–based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community–based behavioral health services;

[(ii) Develop and implement a payment system incorporating the findings of the rate–setting study conducted under item (i) of this paragraph, including projected costs of implementation and recommendations to address any potential shortfall in funding; and**]**

(II) REVIEW AND IMPLEMENT THE RECOMMENDATIONS OF THE WORKGROUP ON BEHAVIORAL HEALTH RATE METHODOLOGY MODERNIZATION ESTABLISHED BY CHAPTER 219 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2026; AND

(III) ADMINISTER COST–REPORTING TOOLS AND OVERSEE COST–REPORT SUBMISSIONS REQUIRED TO SUPPORT THE STUDY REQUIRED UNDER ITEM (I) OF THIS PARAGRAPH.

(3) THE COMMISSION SHALL ASSIST THE DEPARTMENT WITH THE FACILITATION OF THE RATE–SETTING STUDY REQUIRED UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION, INCLUDING BY:

[(iii)**] (I) [**Consult**] CONSULTING** with stakeholders, including community providers and individuals receiving services**[**, in conducting the rate–setting study and developing the payment system required by this paragraph**]; AND**

(II) PROVIDING ANALYTICAL SUPPORT AND TECHNICAL ASSISTANCE.

(4) THE BEHAVIORAL HEALTH ADMINISTRATION AND THE MEDICAL CARE PROGRAMS ADMINISTRATION JOINTLY SHALL:

(I) DEVELOP AND IMPLEMENT A PAYMENT SYSTEM INCORPORATING THE FINDINGS OF THE RATE–SETTING STUDY CONDUCTED UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION; AND

(II) CONSULT WITH STAKEHOLDERS, INCLUDING COMMUNITY PROVIDERS AND INDIVIDUALS RECEIVING SERVICES, IN DEVELOPING THE PAYMENT SYSTEM REQUIRED UNDER ITEM (I) OF THIS PARAGRAPH.

[(2) The Administration, on or before September 30, 2019, shall complete the study required under paragraph (1)(i) of this subsection.**]**

[(3)**] (5)** The Administration shall adopt regulations to implement the payment system required by paragraph **[**(1)**] (4)(I)** of this subsection.

(6) (I) THE SECRETARY, OR THE SECRETARY'S DESIGNEE, SHALL DESIGNATE A REPRESENTATIVE OF THE ADMINISTRATION TO SERVE AS A TECHNICAL LIAISON BETWEEN THE DEPARTMENT AND THE COMMISSION.

(II) THE TECHNICAL LIAISON SHALL:

1. PROVIDE TECHNICAL INPUT FOR THE COMPLETION OF THE STUDY REQUIRED UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION REGARDING MEDICAID POLICY, BEHAVIORAL HEALTH REIMBURSEMENT STRUCTURES, AND EXISTING DATA SOURCES;

2. ENSURE CONTINUITY BETWEEN THE DEPARTMENT'S WORK REGARDING THE COMPLETION OF THE STUDY REQUIRED UNDER PARAGRAPH (2)(I) OF THIS SUBSECTION AND THE COMMISSION'S FACILITATION OF THE WORKGROUP ON BEHAVIORAL HEALTH RATE METHODOLOGY MODERNIZATION ESTABLISHED UNDER CHAPTER 219 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2026; AND

3. COORDINATE THE COMMISSION'S ACCESS TO EXISTING ANALYTICAL WORK OR STUDY PREPARATION THAT HAS BEEN COMPLETED BY THE DEPARTMENT IN COMPLYING WITH PARAGRAPH (2) OF THIS SUBSECTION.

(h) (1) On or before **[**December**] JANUARY** 1, **[**2018**] 2028**, the **[**Department**] COMMISSION** shall submit an interim report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly on **[**the**]:**

(I) THE delivery system through which community–based behavioral health services should be provided**;**

(II) THE STATUS OF THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE WORKGROUP ON BEHAVIORAL HEALTH RATE METHODOLOGY MODERNIZATION ESTABLISHED UNDER CHAPTER 219 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2026; and **[**any**]**

(III) ANY preliminary recommendations regarding the payment system required under this section.

(2) On or before December 1, **[**2019**] 2028**, and on or before December 1 each year thereafter, the **[**Department**] COMMISSION** shall submit a report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General

Assembly on the impact of the rate adjustments and the payment system required under this section on community providers, including the impact on:

(i) The wages and salaries paid and the benefits provided to direct care staff and licensed clinicians employed by community providers;

(ii) The tenure and turnover of direct care staff and licensed clinicians employed by community providers; and

(iii) The ability of community providers to recruit qualified direct care staff and licensed clinicians.

(3) The **[**Department**]** **COMMISSION** may require a community provider to submit, in the form and manner required by the **[**Department**]** **COMMISSION**, information that the **[**Department**]** **COMMISSION** considers necessary for completion of the report required under paragraph (2) of this subsection.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) There is a Workgroup on Behavioral Health Rate Methodology Modernization in the Maryland Health Care Commission.

(b) The purpose of the Workgroup is to develop transparent, cost–based reimbursement methodologies for certified community behavioral health clinics ~~and~~, outpatient mental health centers, and independent outpatient providers using federally required and existing cost–study data as the foundation for future rate reform.

(c) The Workgroup consists of the following members:

(1) ~~two members~~ *one member* of the Senate of Maryland, appointed by the President of the Senate;

(2) ~~two members~~ *one member* of the House of Delegates, appointed by the Speaker of the House;

(3) the Executive Director of the Maryland Health Care Commission, or the Executive Director's designee;

(4) one representative of the Maryland Medical Assistance Program, designated by the Secretary of Health;

(5) ~~one~~ the representative of the Behavioral Health Administration~~, appointed by the Secretary of Health~~ designated as technical liaison under § 16–201.3(e)(6) of the Health – General Article, as enacted by Section 1 of this Act;

(6) three representatives of community behavioral health providers designated by the Community Behavioral Health Association of Maryland, including:

(i) at least one provider from a certified community behavioral health clinic participating in the federal demonstration; and

(ii) at least one provider from an outpatient mental health center; ~~and~~

(7) one representative of the Licensed Clinical Professional Counselors of Maryland, designated by the President of the Association; ~~and~~

(8) one representative of MedChi, the Maryland State Medical Society, designated by the Executive Director of MedChi; and

~~(7)~~ ~~(8)~~ *(9)* the following members, jointly appointed by the Speaker of the House and the President of the Senate:

(i) one representative of a statewide hospital association;

(ii) one representative of a specialty psychiatric hospital;

(iii) one representative of a consumer or peer–led behavioral health advocacy organization;

(iv) one independent actuarial or health–economics expert with Medicaid experience; and

(v) any additional members determined necessary by the cochairs in consultation with the Workgroup.

(d) The President of the Senate and the Speaker of the House jointly shall designate one legislative member and one provider member to serve as cochairs of the Workgroup.

(e) The Maryland Health Care Commission, in consultation with the Maryland Department of Health, the Department of Legislative Services, and the Community Behavioral Health Association of Maryland, shall provide staff for the Workgroup.

(f) A member of the Workgroup:

(1) may not receive compensation as a member of the Workgroup; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) The Workgroup shall:

(1) use the federally required certified community behavioral health clinic cost study as the baseline dataset for evaluating outpatient mental health service costs in the State;

(2) review and analyze cost drivers for outpatient behavioral health services, including:

(i) staffing mix and workforce models;

(ii) medical director and clinical supervision requirements;

(iii) contractor versus salaried ~~employment~~ structures;

(iv) geographic and volume variation; ~~and~~

(v) compliance with State and federal regulatory requirements, including COMAR 10.63; ~~and~~

(vi) differentiation of costs between nonprofit and for–profit organizations;

(vii) ratio of services delivered by telehealth; and

(viii) size and volume of group–based services;

(3) approve methodologies for analyzing outpatient costs and the Maryland Department of Health's completion of the study required under § 16–201.3(e)(2)(i) of the Health – General Article, as enacted by Section 1 of this Act, that include:

(i) cost reporting structures;

(ii) sampling methodologies that exclude all programs founded after 2020;

(iii) allocation of overhead and administrative costs;

(iv) differentiation of the treatment of revenues of providers that are from Medicaid and sources other than Medicaid; and

(v) modeling approaches used to estimate sustainable reimbursement rates;

~~(3)~~ (4) evaluate reimbursement methodologies used in other states and federal demonstration programs;

~~(4)~~ (5) (i) subject to item (ii) of this item, develop one or more cost–based, rate–setting methodologies applicable to ~~both~~ certified community behavioral health clinics ~~and~~, outpatient mental health centers, and independent outpatient providers that include:

1. re–evaluating and rebasing reimbursement rates under the Certified Community Behavioral Health Clinic Payment Model in demonstration year two and every 3 years thereafter;

2. assumptions, cost–model components, and inflationary adjustments; and

3. integration of data and analyses produced under the cost–driven rate–setting study required under § 16–201.3(e)(2)(i) of the Health – General Article, as enacted by Section 1 of this Act, to the extent the data and analyses are available; and

(ii) build on all previously completed and ongoing cost–reporting and analytical work related to setting community provider rates for community–based behavioral health services in developing methodologies under item (i) of this item, including, to the extent available:

1. the independent cost–driven analysis required under § 16–201.3(e)(2)(i) of the Health – General Article, as enacted by Section 1 of this Act;

2. the certified community behavioral health clinic cost and rate study required by the 2025 Joint Chairmen's Report; and

3. cost reporting tools and submission review processes required under § 16–201.3(e)(2)(iii) of the Health – General Article, as enacted by Section 1 of this Act;

~~(5)~~ (6) ensure all recommended methodologies comply with both federal Medicaid financing rules and the Medicaid Upper Payment Limit and provide recommendations on strategies to implement the recommended methodologies while remaining compliant with federal requirements;

~~(6)~~ (7) identify any regulatory or statutory barriers to statewide implementation of cost–based, rate–setting methodologies; and

~~(7)~~ (8) propose options for phased statewide implementation of cost–based, rate–setting methodologies when fiscal conditions allow.

~~(g)~~ (h) (1) On or before ~~December 1, 2026~~ June 1, 2027, the Workgroup shall submit an interim report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(2) On or before ~~October~~ December 1, 2027, the Workgroup shall submit a final report to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly that includes:

(i) recommended rate–setting methodologies;

(ii) assumption and cost–model components;

(iii) options for phased implementation;

(iv) estimated fiscal considerations; and

(v) any recommended statutory or regulatory changes.

~~(h)~~ (i) This section does not:

(1) require an immediate rate increase;

(2) mandate an appropriation; or

(3) create a fiscal obligation in the absence of subsequent legislative or budgetary action.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2026. ~~It~~ Section 2 of this Act shall remain effective for a period of 2 years and, at the end of June 30, 2028, Section 2 of this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

Approved by the Governor, April 28, 2026.