LEGAL ACTION CENTER

Behavioral Health Care – Treatment and Access (Behavioral Health Model for Maryland) (HB 1148)
Health and Government Operations Committee Hearing
February 28, 2023
SUPPORT WITH AMENDMENTS

Thank you for the opportunity to submit testimony **in support of HB 1148 with amendments** to (1) create a Commission on Behavioral Health Care Treatment and Access and (2) extend the coverage of audio-only telehealth and payment parity for both audio-only and audio-visual telehealth for two years pending a study on payment parity. This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health (MH) and substance use disorder (SUD) services through enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act).

I. Creation of Commission on Behavioral Health Care Treatment and Access

The General Assembly has taken important steps to improve access to SUD and MH care in the face of the state's worst overdose epidemic and mental health crisis. The proposed Commission would (1) examine and make recommendations to further improve the MH and SUD health care delivery system, and, in doing so, (2) help ensure coordination of programs and services across the public and private payer systems and all state agencies whose programmatic work involves services for individuals with MH and SUDs. All Marylanders are affected by these health conditions, and the failure to provide affordable, effective, and timely care results in death and despair in families as well as significant, but avoidable, costs to our health, criminal legal, social services and unemployment systems. These burdens fall most harshly on Black and brown Marylanders.

To ensure the Commission will achieve is purpose, we offer proposed amendments to:

- Include appropriate representation from the substance use disorder treatment and consumer communities on the Commission; and
- Incorporate key federal priorities in the Commission's work, including enforcement of the Parity Act, improving integration of the SUD and MH services in medical care settings, and adoption of Medicaid Reentry for individuals in carceral settings.

We also seek clarification of the Commission's role as it relates to future legislation.

A. Commission Membership – Section 13-4803

The Commission's membership is understandably broad to include representation from government agencies, non-governmental organizations, payer systems, and persons with lived experience in providing and receiving SUD and MH care. Sec. 13-4803(a). Several notable entities with expertise in SUD care and financing have not been included in the Commission's membership, which we believe will weaken its deliberations and recommendations. Maryland ranked 7th in highest overdose death rates in the country in the year ending April 2021, and Black Marylanders have experienced substantial and disproportionate increases in fatal overdoses. **To ensure that all state efforts are focused on helping Marylanders with SUDs, the Commission must have all the right people at the table.**

We support the recommendations of NCADD-Maryland to fill out the Commission's membership. We also recommend that the provision related to the composition of the membership (Sec. 13-4803(b)) be amended to ensure that it reflects Maryland's racial and gender diversity as well as its geographic and ethnic diversity. (*See* Attachment A, Amendment 1).

B. Commission Purpose – Section 13-4804

We agree that one of the Commission's purposes should be to make recommendations for the delivery of MH and SUD services across the care continuum. We urge the Committee to clarify that the goals of that care include "affordable" and "equitable" care in addition to the metrics of "appropriate, accessible and comprehensive" and that these standards apply in both the public and private insurance systems.

Additionally, we urge the Committee to explicitly require the Commission to serve in a coordination role so that (1) state agencies and the public are well informed of the SUD and MH programmatic work across the government and (2) the respective agencies have an opportunity to coordinate their work, as appropriate. (*See* Attachment A, Amendment 2).

We also seek clarification of the intended role of the Commission for purposes of future legislation. We appreciate the broad mission of the Commission and agree that the Commission's work will lead to some legislative proposals. We also expect that other issues and legislation related to improving access to MH and SUD care will arise outside the Commission's work. **We urge the Committee to clarify that the Commission does not need to be involved in all future legislative proposals related to behavioral health through its development, review, vetting or other actions.**

C. Commission Functions – Section 13-4805

HB 1148 covers a wide range of important tasks and inquiries. We offer several recommendations to ensure that the product of that work is appropriately comprehensive and focused on the coverage and delivery of **non-discriminatory and Parity Act compliant benefits and services**. We also offer additional recommendations to ensure that Maryland's care model incorporates several federal priorities that will improve access to SUD and MH care.

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1. Needs Assessment

We agree that a needs and gaps assessment is an appropriate starting point for the Commission's work. To ensure a complete landscape review, we recommend that the needs assessment:

- include additional services along the care continuum, including "harm reduction," "office-based services for opioid use disorder (OUD) and substance use disorder care," and "recovery services;" and
- explicitly require an examination of services in both the public and private payer systems with attention to service coverage that complies with the Mental Health Parity and Addiction Equity Act.

Harm reduction activities are highly effective in saving lives, delivering essential health services to prevent and treat diseases and wounds, and offering a bridge to SUD and MH treatment. Office-based services for OUD treatment must be expanded to meet the needs of Marylanders, and the recent elimination of the X-waiver requirement for buprenorphine prescribing will remove one key obstacle to expanding office-based practices. Finally, recovery services are part of the essential continuum of services for the treatment of these chronic conditions.

These services should be available in both the public and private payer systems. All too often, care costs that should be borne by private insurance are shifted to the public system. The Parity Act was enacted to ensure that coverage of MH and SUD benefits is comparable to and no more restrictive than benefit coverage for medical/surgical care. Maryland has incorporated the federal standards into state law and requires compliance reporting that should inform and advance the Commission's work. INS. §§ 2-109 and 15-802; COMAR § 31.10.51. **We urge the Committee to amend the bill to incorporate this standard in the service coverage task.** (*See* Attachment A, Amendment 3).

Given the importance of the needs and gaps assessment and the short timeline for conducting the assessment, **we urge the Committee to amend the bill to designate the entity that is responsible for conducting the assessment and provide designated funding to conduct the assessment, allowing for non-governmental agency assistance.** Finally, we believe that the needs assessment tasks in Sections 13-4804(1) and 13-4804(3) overlap and should be combined in a single provision.

We also note that the requested workforce needs assessment (Sec. 13-4805(5)) overlaps with a similar needs assessment to be conducted under **HB 418/SB283** – Mental Health – Workforce Development Fund. We trust that this work will be coordinated.

2. Reimbursement of SUD and MH Services

We agree that the Commission should thoroughly examine reimbursement methodologies and practices for both public and private insurance and also ensure that all reimbursement practices comply with the Parity Act. A 2019 report by Milliman found that in-network reimbursement rates for MH and SUD services were substantially lower than reimbursement rates for primary medical care and med/surg specialty care: primary care payments were 18.2% higher than payments for MH/SUD care and specialty medical/surgical

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care payments were 11.3% higher. The Maryland Insurance Administration is examining reimbursement rates as part of its parity compliance reporting, and that information should help inform the Commission's work. We also note that Maryland Medicaid has never conducted an examination of parity compliance for its reimbursement rate setting practices for MH and SUD services, notwithstanding a federal requirement to do so annually. We urge the Committee to amend Sec. 13-4805(2) to ensure the Commission uses this critical legal tool to improve access to MH and SUD care. (*See* Attachment A, Amendment 4).

3. Treatment Services for Court-Ordered Individuals

Nearly 70% of individuals in Maryland's jails have a SUD, 39% have a MH condition and 35% have a co-occurring MH and SUD condition. Among the State's prison population, one-third of the individuals have a "serious drug related problem and one in five individuals has a mental illness. (Governor's Office of Crime Control and Prevention, Substance Use and Mental Health Disorder Gaps and Needs Analysis, Dec. 31, 2016). An overwhelming majority – 71.5% -- of individuals in state prisons are Black. (Maryland Dept. of Public Safety and Correctional Services, July 2022 Inmate Characteristics). HB 1148 would appropriately require the Commission to make recommendations to expand access to MH and SUD care for individuals involved in the criminal legal system, which is also needed to begin to address racial discrimination.

As justice-involved individuals return to their communities, the State must do all it can to ensure that they are connected seamlessly to SUD and MH services. A federal initiative that many states are exploring is Medicaid Reentry, which allows Medicaid to cover the final 30-90 days of SUD care for individuals in carceral settings through an 1115 waiver. CMS just approved this authority for California and will issue guidance soon outlining how states can use Medicaid funds for treatment before people are released. **We urge the Committee to require the Commission to make recommendations related to the adoption of Medicaid-Reentry to help prevent overdose deaths, reduce medical, legal and social service costs, and ensure effective care delivery to this very vulnerable population.** This funding mechanism will support the State's current efforts to screen individuals in jails for opioid use disorder, assess treatment needs and provide medications and other services. (Maryland Dept. of Public Safety and Correctional Services, SUD and MAT Report, Nov. 1, 2021) (*See* Attachment A, Amendment 5).

4. Additional Commission Activities

We urge the Committee to task the Commission with three additional sets of inquiries and recommendations to ensure that Marylanders can access SUD and MH services effectively. **First, a federal treatment priority is to improve integration of substance-use related prevention and treatment in general health care settings, ending the long-standing siloed delivery system for SUD care.** As the U.S. Surgeon General has observed, "Integrating services for primary care, mental health and substance use-related problems together produces the best outcomes and provides the most effective approach for supporting whole-person health and wellness." (U.S. Dept. of Health and Human Services, Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, Nov. 2016, at 6-1). Integration is essential to build a larger, more diverse workforce that has the expertise to prevent, identify and treat SUD. We urge the Committee to include within the Commission's tasks the evaluation and recommendations for improved integration of SUD care

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in general health care settings in Maryland, including hospital emergency departments.

Second, as noted above, harm reduction is an essential component of the health care continuum for SUD care. While Maryland has undertaken important steps to expand syringe services programs and other harm reduction practices, the state should adopt a comprehensive plan that includes Overdose Prevention Sites and other tools. **We urge the Committee to require the Commission to evaluate and make recommendations for the adoption of the full complement of harm reduction practices.**

Third, providing comprehensive coverage of SUD and MH services is meaningless if Marylanders cannot access those services through their insurance in a timely way. In the midst of a crisis, individuals and families need support to understand and navigate their insurance coverage, locate a network provider, and, if denied prescribed care, challenge the denial. Other states have established consumer assistance programs to provide on-the-ground client assistance and representation, address system-wide problems and enforce the Parity Act to ensure non-discriminatory coverage. In 2022, the Senate passed the Consumer Health Access Program to meet this need (SB 460). A Working Group convened by the Maryland Insurance Administration reached consensus that consumer assistance is needed and not offered by any other entity it the state. It could not reach consensus on the structure for delivering this service. **We urge the Committee to task the Commission with establishing the Consumer Health Access Program as quickly as possible**. (*See* Attachment A, Amendment 6).

Finally, we note that NCADD-Maryland has several additional amendments related to the Commission. We support those amendments.

II. Continuation of Telehealth Standards in Public and Private Insurance

Continuation of existing telehealth standards in both private and public insurance is a top priority of the Maryland Parity Coalition. In 2021, the Maryland Parity Coalition advocated for comprehensive telehealth services, and members participated actively in the Maryland Health Care Commission's (MHCC) telehealth study, the basis of SB 534's recommendations. The MHCC's findings capture the on-the-ground experience of the Coalition's consumer and provider members. **The study highlights the critical importance of telehealth services for MH and SUD care and overwhelming support for "maintain[ing] a choice of care modalities, including audio-only, audio-visual, and in-person visits."**[1] Among Maryland's mental health and substance use disorder providers:

- The vast majority use audio-visual telehealth (98%) and audio-only telehealth (67%) and would like to increase their use of telehealth services.
- Virtually all – 97% - found that both modes of telehealth improve access to care, particularly for patients who might otherwise face access-related barriers.
- The vast majority believe that audio-visual (89%) and audio-only (60%) are as good as in-person services.[2]

Research reinforces the MHCC's findings that audio-only telehealth is effective for many MH and SUD services[3] and must be continued, pending infrastructure development, to ensure equity. Ending coverage of audio-only treatment would hinder access to care and exacerbate health disparities for rural, older, lower-income, non-English speaking, and Black and brown populations due to on-going structural gaps in accessing in-person and audio-visual

telehealth services.[4]

Continuation of audio-only telehealth is also essential to align with federal standards for the treatment of opioid use disorder (OUD) in clinical settings. The Substance Abuse and Mental Health Services Administration (SAMHSA) has recently issued proposed rules for medications for opioid use disorder (MOUD) that would permit, *on a permanent basis*, initiation of buprenorphine treatment via audio-visual and audio-only telehealth and methadone treatment via audio-visual telehealth.[5] The Drug Enforcement Administration (DEA), which issued a temporary exception to permit prescribing of controlled substances via telehealth during the federal COVID public health emergency, is expected to issue regulations to authorize the prescribing of MOUD via telehealth.

Continuing payment parity for both public and private payer is necessary to meet the cost of care delivery and ensure that telehealth remains available to all Marylanders without regard to income, race, or place of residence. As MHCC reported, for MH and SUD providers, "audio-only and audio-visual telehealth requires the same provider effort and fixed costs…as in-person costs,"[6] including office related expenses and administrative costs. Research supports the conclusion that clinical effort, malpractice expenses, and fixed costs for practitioners who deliver in-person and telehealth services remain the same across service delivery modes.[7] Small and solo practices – common in the MH and SUD care context – and those in underserved communities that are not highly resourced are least able to support telehealth without adequate reimbursement.[8] **Marylanders who do not have the financial resources, technical ability, or broadband availability to use audio-visual telehealth would have far more limited care access absent payment parity:** 70% of MH and SUD providers reported that low reimbursement from commercial payers is a barrier to providing audio-only services, and 40% indicated that lack of reimbursement would be a reason for discontinuing audio-only services.[9]

Finally, as the General Assembly moves forward to continue audio-only telehealth and payment parity in both public and private insurance until June 2025, **we urge the General Assembly to continue to protect the right of Marylanders to choose the mode of service delivery that is most appropriate for them – telehealth, in-person or a hybrid approach.** Maryland law protects this right for those seeking MH or SUD services (INS. § 15-139(c)(1)(iii); HEALTH GEN. § 15-141.2(d)(2)), and those protections should not be altered.

While telehealth is critically important for accessing MH and SUD care, the majority of MH and SUD outpatient care is still delivered in person. The share of MH and SUD outpatient visits delivered via telehealth reached a peak of 40% during the pandemic (at varying rates for different conditions).[10] Since that time, practitioners who treated patients with opioid use disorder reported a decline in telehealth use from December 2020 to March 2022 – going from 56.7% to 41.5% of all OUD visits.[11] Telehealth is an important complement to in-person care but will not replace in person care. **Adequate protections must remain in place to ensure robust availability of in-person MH and SUD services in public and private insurance.**

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Thank you for considering our views. We urge the Committee to issue a favorable report with amendments on HB 1148.

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[1] NORC, Technical Report of the Maryland Telehealth Study (Oct. 28, 2022) at 16. Finding that "[t]here was consensus that telehealth offered greater access to behavioral health, fostering immediate access to patients in crisis, reducing transportation barriers, improving ease of scheduling, and allowing increased flexibility for patients and providers. Provider organization participants further noted that telehealth decreased no-show rates and lapses in care for ongoing mental health treatment." https://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/hit_norc_technical_rpt.pdf

[2] NORC at 18-20.

[3] *See* Madeline C. Frost et al., "Use of and Retention on Video, Telephone, and In-Person Buprenorphine Treatment for Opioid Use Disorder During the COVID-19 Pandemic," JAMA Network Open (Oct. 12, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797201; Patricia V. Chen et al., "Evidence of Phone vs Video-Conferencing for Mental Health Treatments: A Review of the Literature," Curr. Psychiatry Rep. (Sept. 2, 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9437398/; Lauren Riedel et al., "Use of Telemedicine for Opioid Use Disorder Treatment – Perceptions and Experiences of Opioid Use Disorder Clinicians," Drug & Alcohol Dependence (Nov. 1, 2021), https://www.sciencedirect.com/science/article/abs/pii/S0376871621004944?dgcid=rss_sd_all.

[4] NORC at 24; Impacts of Eliminating Audio-Only Care on Disparities in Telehealth Accessibility," J. Gen. Internal Med. (Apr. 11, 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8999992/pdf/11606_2022_Article_7570.pdf; and Sarah Bhatnager et al., "The Future of Telehealth after COVID-19: New Opportunities and Challenges," Bipartisan Policy Center (October 2022), https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/09/BPC-The-Future-of-Telehealth-After-COVID-19-October-2022.pdf;

[5] Dept. of Health and Human Services, Medications for the Treatment of Opioid Use Disorder, 87 FED. REG. 77330, 77336-37 and Sec. 8.12(f)(2)(v) (Dec. 16, 2022).

[6] NORC at 46.

[7] Chad Ellimoottil, "Understanding the Case for Telehealth Payment Parity," Health Affairs Forefront (May 10, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210503.625394/full/

[8] Andrew C. Philip et al., "Getting Beyond Parity: Telehealth as a Best Practice in Health Equity," Telehealth & Medicine Today (Jan. 31, 2022), https://telehealthandmedicinetoday.com/index.php/journal/article/view/303/611; and Ellimoottil, *supra* note 7..

[9] NORC at 47-48.

[10] Justin Lo et al., "Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic," Kaiser Family Foundation (Mar. 15, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/

[11] Lori Uscher-Pines, et al., "Many Clinicians Implement Digital Equity Strategies to Treat Opioid Use Disorder, 42 Health Affairs 182, 183 (Feb. 2023), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00803.

Attachment A

ATTACHMENT A
PROPOSED AMENDMENTS – HB 1148
Legal Action Center

1. Amendment 1 – Composition of Commission 13-4803(B).

p. 5, lines 4-5. Add "**GENDER AND RACIAL**" after "GEOGRAPHIC".

2. Amendment 2 – Purpose of Commission – 13-4804

p. 5, line 18. Add "**AFFORDABLE AND EQUITABLE**" after "ACCESSIBLE".

p. 5, line 20. Add "**IN BOTH PUBLIC AND PRIVATE INSURANCE SYSTEMS**" after "CONTINUUM."

p. 5, line 17. Add **"(1)"** after "TO" and before "MAKE".

Add new **"(2) ENSURE COORDINATION OF STATE AGENCY MENTAL HEALTH AND SUBSTANCE USE DISORDER ACTIVITIES."**

3. Amendment 3 – Commission Activities – 13-4805(1) – Needs Assessment

p. 5, line 24. Add "**PUBLIC AND PRIVATE INSURANCE**" after "CONTINUUM."

p. 5, line 25. Add **"HARM REDUCTION," "OFFICE-BASED SERVICES FOR OPIOID USE DISORDER AND SUBSTANCE USE DISORDER CARE" AND "RECOVERY SERVICES"**

p. 5, line 26. Add "**AND TO IDENTIFY SERVICES THAT ARE NEEDED TO COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.**"

The revised provision would read:

(1) CONDUCT AN ASSESSMENT OF BEHAVIORAL HEALTH SERVICES IN THE STATE TO

(I) IDENTIFY NEEDS AND GAPS IN SERVICES ACROSS THE CONTINUUM **IN PUBLIC AND PRIVATE INSURANCE**, INCLUDING **HARM REDUCTION**, COMMUNITY-BASED OUTPATIENT AND SUPPORT SERVICES, **OFFICE-BASED SERVICES FOR OPIOID USE DISORDER AND SUBSTANCE USE DISORDER CARE,** CRISIS RESPONSE, ~~AND~~ INPATIENT CARE AND **RECOVERY SERVICES, AND**

(II) **TO IDENTIFY SERVICES THAT ARE NEEDED TO COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.**

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PROPOSED AMENDMENTS – HB 1148
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4. **Amendment 4 – Commission Activities – 13-4805(2) – Reimbursement Practices**

p. 5, line 29. Add **"AND REIMBURSEMENT STANDARDS THAT COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT"** after "DELIVERY."

5. Amendment 5 – Commission Activities – 13-4805(10) – Services for Justice-Involved Individuals

p. 6, line 23. Add **"INCLUDING THE ADOPTION OF MEDICAID REENTRY TO AUTHORIZE MEDICAID, UNDER 1115 WAIVER AUTHORITY, TO PAY FOR SUBSTANCE USE DISORDER AND MENTAL HEALTH CARE PRIOR TO THE RELEASE OF ELIGIBLE INDIVIDUALS FROM DETENTION, JAIL OR PRISON"** after "POPULATION."

6. AMENDMENT 6 – Commission Activities – 13-4805 – Additional Tasks

p. 6 or 7. Add the following 3 amendments.

(13) EVALUATE AND MAKE RECOMMENDATIONS TO IMPROVE INTEGRATION OF SUBSTANCE USE DISORDER CARE IN GENERAL HEALTH CARE SETTINGS, INCLUDING EMERGENCY DEPARTMENTS AND SKILLED NURSING FACILITIES.

(14) EVALUATE AND MAKE RECOMMENDATIONS FOR THE ADOPTION OF COMPREHENSIVE HARM REDUCTION STRATEGIES FOR SUBSTANCE USE DISORDERS.

(15) MAKE RECOMMENDATIONS FOR THE PROMPT ESTABLISHMENT OF A CONSUMER ASSISTANCE PROGRAM TO ASSIST INDIVIDUALS ACCESS CARE FOR SUBSTANCE USE DISORDER AND MENTAL HEALTH CARE THROUGH ALL FORMS OF PUBLIC AND PRIVATE INSURANCE AND ADDRESS SYSTEM-WIDE BARRIERS TO BEHAVIORAL HEALTH CARE.