



# MARYLAND Department of Health

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

June 5, 2019

The Hon. Delores G. Kelley, Chair  
Senate Finance Committee  
3 East, Miller Senate Office Building  
Annapolis, Maryland 21401

The Hon. Shane E. Pendergrass, Chair  
House Health and Government Ops. Committee  
Room 241, House Office Building  
Annapolis, Maryland 21401

Re: **Medicaid – Managed Care Organizations – Behavioral Health Services** (House Bill 846 / Senate Bill 482; House Bill 938 / Senate Bill 975; and House Bill 941 / Senate Bill 976)

Dear Chairs Kelley and Pendergrass:

Thank you for your correspondence, dated April 29, 2019, regarding the various delivery of behavioral health care bills from the 2019 legislative session. As noted previously in the Department of Health (Department) letter of information (attached) on House Bill 846 / Senate Bill 482, Maryland stands to benefit greatly from a carefully considered approach towards how we provide, administer, and pay for behavioral health care.

The Department agrees with the committees' suggestion to engage a workgroup on this important issue. We have begun the process of convening a stakeholder group to discuss the design of the behavioral health system of care with representatives from the provider, advocate, consumer, and legislative communities. We welcome the participation of specific individuals that the committees wish to refer to this workgroup. As the stakeholder group evolves and begins to meet over the summer, the Department looks forward to engaging with our partners.

The Department views the topic of behavioral health "carve-in" within the lens of two important initiatives and believes that any stakeholder group discussion needs to be cognizant and aware of (1) the Total Cost of Care Model; and (2) the work of the Governor's Commission to Study Mental and Behavioral Health in Maryland.

As noted both in our previous letter to the committees and your April 29th correspondence, whatever solution or roadmap that Maryland adopts must fit within the fiscal and other contractual provisions of the Total Cost of Care Model (TCOC Model). As Maryland moves toward the TCOC Model's first phase implementation by 2023, and second phase implementation by 2029, we must ensure that our system of care investments are appropriately 'counted' and in line with the federal contract's objectives. The TCOC Model is currently addressing this issue through a stakeholder innovation group, led by the Maryland Hospital Association, the Department and the Health Services Cost Review Commission, and other health partners. The Department believes that any recommendations from the stakeholder group and subsequent actions by the Department need to be realizable goals through the TCOC Model's implementation framework.

The Governor signed an executive order on January 10, 2019 and amended on May 28, 2019, which created the Governor's Commission to Study Mental and Behavioral Health. The purpose of the Commission is to provide a forum for Maryland to ensure a coordinated, high quality system of care by coordinating state agencies, local governments, and community partners to establish near-term goals, best practices, and improve the state's public mental health system. The Commission is planning to submit an interim report by summer 2019 and an annual report by December 31, 2019. As stated in the executive order, the Commission's annual report must include, but is not limited to, recommendations for policy, regulations, or legislation to improve the statewide, comprehensive crisis response system and ensure parity of resources to meet mental health needs. The Commission has created four subcommittees to work through these issues – Finance and Funding, Youth and Families, Crisis Services, and Public Safety and Judicial System. The Department believes that discussion of the overall strategic objectives of the behavioral health system of care will stem from the Commission's work.

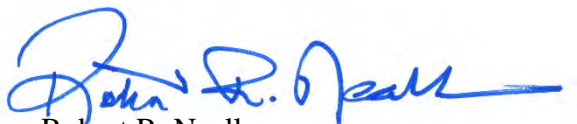
Finally, for a well-functioning behavioral health care system, the Department believes three core principles should be addressed: Quality Integrated Care Management, Cost Management, and Provider Management.

- **Quality Integrated Care Management:** We must ensure that our State's health care providers are delivering quality health care that will address our citizens' substance use disorder and mental health needs. A critical "yardstick" measurement is whether we are able to reduce the number of opioid-related fatalities each year by linking Marylanders in need with the health care that can save their lives.
- **Cost Management:** As noted by the Department of Legislative Services' budget analysis of Medicaid and other independent studies, the Department strongly believes that while the fee-for-service transition of substance use disorder health care has made health care more accessible to Marylanders, we now need to plan for the next ten years and ensure that cost containment measures are emplaced that are effective and designed for the long-term.
- **Provider Management:** We must ensure that Marylanders are able to easily access health care providers and minimize the administrative burden on behavioral health care providers.

In addition, the Department plans to integrate its mandated independent, cost-driven, rate setting study to set community provider rates for community-based behavioral health services so that the end product from all of these deliberations result in specific, realizable goals and objectives.

Thank you for your committees' interest in this very important subject. If you have any questions, please do not hesitate to contact me at 410.767.4639 or Webster Ye, Director of Governmental Affairs, at 410.767.6481 or at [webster.ye@maryland.gov](mailto:webster.ye@maryland.gov).

Sincerely,



Robert R. Neall  
Secretary



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

March 6, 2019

The Honorable Shane E. Pendergrass  
Chair, House Health and Government Operations Committee  
241 House Office Building  
Annapolis, Maryland 21401

**RE: HB 846 – Maryland Medical Assistance Program – Managed Care Organizations – Behavioral Health Services - Letter of Information**

Dear Chair Pendergrass and members of the House Health and Government Operations Committee:

The Maryland Department of Health (Department) respectfully submits this letter of information on House Bill 846 -- Maryland Medical Assistance Program – Managed Care Organizations – Behavioral Health Services.

We thank HB846's bill sponsors, along with the many other members who have sponsored bills on the subject of transforming Maryland's behavioral health care system this session for starting an important conversation. We also thank Chair Kelley for her initial efforts at bringing stakeholders together to discuss the Senate cross-file, SB482, last week.

The Department believes that over the next four years, and as part of our implementation of the Total Cost of Care Model, Maryland stands to benefit greatly from a carefully considered approach towards how we provide, administer, and pay for behavioral health care. Whatever approach is ultimately decided upon this session, whether it be a full implementation mandate, a transition workgroup, or adjustments to the existing system, should address a few key principles, as discussed below.

For a well-functioning behavioral health care system, the Department believes three components should be addressed: Quality Integrated Care Management, Cost Management, and Provider Management.

- **Quality Integrated Care Management:** reduced to its most basic elements, is ensuring that our State's health care providers are delivering quality health care that will address our citizens' behavioral and mental health needs. A critical "yardstick" measurement is whether we are able to reduce the number of opioid-related fatalities each year by linking Marylanders in need with the health care that can save their lives.
- **Cost management:** as noted by the Department of Legislative Services' budget analysis of Medicaid and other independent studies, the Department strongly believes that while the fee-for-service transition of behavioral health care has made health care more accessible to Marylanders, we now need to plan for the next ten years and ensure that cost containment measures are emplaced that are effective and designed for the long-term.



- **Provider management:** whatever system of behavioral health care Maryland embarks upon, we must ensure that Marylanders are able to easily access health care providers.

The Department believes that the current Administrative Services Organization (ASO) addresses Provider Management and ensures access to care. Over the past few years, we have focused on ensuring, especially with the recent provider transition to behavioral health fee-for-service, that Maryland's behavioral health care providers are accredited by one of four national accreditation organizations, and subsequently licensed by the Department's Behavioral Health Administration. Those accredited and licensed providers are able to enroll as a Medicaid-eligible provider. We believe that through this process, a minimum baseline of care is provided and that we are able to adequately track geographic availability. The existing system does not provide limited Care Management or Cost Management. Whatever system that is put in place must be designed to provide all three of these principles.

HB846, if enacted, would require the HealthChoice managed care organizations (MCOs) to be financially and administratively responsible for the behavioral health services (mental health and substance use services) for all HealthChoice enrollees. Currently these services are managed by an Administrative Services Organization (ASO) and reimbursed by the Medicaid Fee-for-Service program. The bill requires the Department to implement this change beginning January 1, 2021.

If HB846 is enacted, the Department will have to make a number of administrative changes to implement the new behavioral health delivery network. It will be critical that the Department has clear direction on how to move forward in order to meet the January 1, 2021 deadline. We have highlighted some of the key changes below.

#### Guidelines for the Carve-In:

The Department will be responsible for working with stakeholders to develop the Behavioral Health services carve-in guidelines. We will need to develop guidelines and protocols in many areas, e.g. covered services, transition of care, carve-in structure, and preauthorization and credentialing requirements. These are all important decisions that will take time to work through.

#### Rate Setting Process:

The Department currently conducts an annual rate-setting process with the MCOs to determine the capitation rates for enrollees in the HealthChoice Program for the upcoming calendar year. The process begins in March and is completed by September. This means we will begin the rate-setting process for CY 2021 rates in February 2020.

It is important that the Department has the opportunity to produce a cost-driven rate system based on a comprehensive review of providers' accounting ledgers. For this to happen, we believe that the cost-driven, rate-setting study envisioned in the HOPE Act of 2017 (Chapter 571, House Bill 1329 of 2017, Section 5), would have to be further expanded to have specific statutory requirements for a behavioral health care provider to provide their costs. The most similar bill in recent years was Chapter 648 of 2014 (House Bill 1238 of 2014) regarding the Developmental Disabilities Administration (DDA). As an example of the time taken, the study was begun in early 2015, and largely complete by Fall 2017 and discussed in the 2018 session of the General Assembly. The report's rate setting recommendations are currently anticipated to be implemented in the CY 2021 DDA provider rates. A scope of work for the behavioral health

rates would likely be broader than the DDA provider rates – it would require analysis of the current fee-for-service rates, providers’ costs and their applicability to the future system of behavioral health care.

Residential Services:

In 2017, Maryland received an amendment to its §1115 HealthChoice Waiver from the federal government that allows the Department to provide reimbursement under Medicaid for up to two non-consecutive 30-day stays annually for American Society of Addiction Medicine (ASAM) levels 3.1, 3.3, 3.5, 3.7, and 3.7WM.<sup>1</sup> Under the waiver agreement, the Centers Medicare and Medicaid Services (CMS) does not pay for the room and board costs of those stays. Maryland is paying providers entirely with General Funds for the room and board costs. In addition, for those who require longer stays in residential treatment centers, Maryland pays for the entire stay using General Funds. These programmatic rules will need to be established well-before the rate-setting process begins in order to provide clarity for patients and providers.

Behavioral Health Administrative Services Organization:

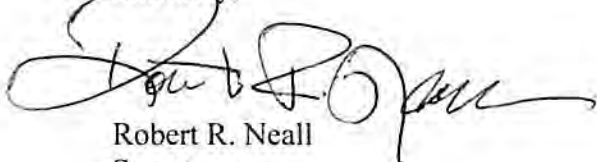
Currently, a Behavioral Health Administrative Services Organization (BH ASO) provides administrative assistance for the Medicaid MCO and Fee-for-Service enrollees. Individuals who are eligible for both Medicare and Medicaid Services (“dually eligible”) and those 65 and older are not enrolled in the HealthChoice Program, as well as certain other groups of ‘specialty’ individuals, including those under the Justice Reinvestment Act. The Department would likely still need to contract with a BH ASO to provide behavioral health services to those individuals.

The current ASO contract expires on December 31, 2019. MDH is in the middle of the procuring a new contract. Depending on the legislative policy guidance received, the Department may take additional actions to change the procurement accordingly.

Again, we urge the committee to carefully consider the many moving parts, some of which are highlighted above, as part of any discussion of a full implementation mandate, a transition workgroup, or continued steps forward under the current behavioral health system.

If you would like to discuss this further, please contact Mr. Webster Ye, Deputy Chief of Staff, at (410) 260-3190 or at [webster.ye@maryland.gov](mailto:webster.ye@maryland.gov).

Sincerely,



Robert R. Neall  
Secretary

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<sup>1</sup> <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/> (Retrieved, March 4, 2019)



# The State of Maryland

## Executive Department

EXECUTIVE ORDER  
01.01.2019.06

Commission to Study Mental and Behavioral Health in Maryland  
(Amends Executive Order 01.01.2019.02)

- WHEREAS, One in five adults experiences a mental health condition every year and one in 17 lives with a serious mental illness;
- WHEREAS, Adults in the United States living with serious mental illness die on average 25 years earlier than others, largely because of treatable medical conditions;
- WHEREAS, Untreated mental illness creates immense economic and human problems, including, but not limited to, homelessness, burdens on the judicial system, victimization, suicide, and violence;
- WHEREAS, Mental illness not only affects the person suffering from it, but also the person's friends, family, and community;
- WHEREAS, Available and accessible early-intervention services can more quickly stabilize, and significantly reduce, preventable behavioral health crises and divert individuals from the criminal justice system, emergency departments, and inpatient hospitalization;
- WHEREAS, 50 percent of those with mental illness experience its effects by age 14 and 75 percent by age 24, making early engagement and support critical for effective intervention;
- WHEREAS, There is a well-documented link between substance-use and mental health disorders as approximately 7.9 million adults in the United States have co-occurring disorders;

WHEREAS, In order to further its ongoing efforts to address the heroin, opioid, and fentanyl crisis, the State must continue to ensure a coordinated, high-quality system of care; and

WHEREAS, Coordination among State agencies, local governments, and community partners is necessary to establish best practices and improve the State's Public Mental Health System;

NOW, THEREFORE, I, LAWRENCE J. HOGAN, JR., GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY AMEND EXECUTIVE ORDER 01.01.2019.02, AND PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Establishment. There is a Governor's Commission to Study Mental and Behavioral Health in Maryland (the "Commission").

B. Membership.

(1) The Commission shall consist of the following members:

- (a) The Lieutenant Governor;
- (b) **TWO APPOINTEES** [An appointee] of the President of the Maryland Senate;
- (c) **TWO APPOINTEES** [An appointee] of the Speaker of the Maryland House of Delegates;
- (d) A representative of the Judicial system of the State, appointed by the Chief Judge of the Court of Appeals;
- (e) The Secretary of the Department of Health, or the Secretary's designee;
- (f) The Deputy Secretary for Behavioral Health, or the Secretary's designee;
- (g) The Secretary of the State Police, or the Secretary's designee;

- (h) The Secretary of Public Safety and Correctional Services, or the Secretary's designee;
- (i) The Secretary of Human Services, or the Secretary's designee;
- (j) The Maryland Insurance Commissioner, or the Commissioner's designee;
- (k) The Executive Director of the Opioid Operational Command Center;
- (l) **THE SECRETARY OF DISABILITIES, OR THE SECRETARY'S DESIGNEE;**
- (m) **THE STATE SUPERINTENDENT OF SCHOOLS, OR THE SUPERINTENDENT'S DESIGNEE;** and
- (n) Six public members, to be appointed by the Governor, representing a range of experience related to mental health, including lived experiences, clinical expertise, work within the criminal justice system, and the provision of social services.

(2) The members serve at the pleasure of the Governor.

(3) Staff members from the Offices of the Governor and Lieutenant Governor, the Governor's Office of Crime Control and Prevention, and the Maryland Department of Health will also be regular participants.

(4) The Chair may also invite other units of State or U.S. government, including law enforcement agencies, to designate representatives for participation.

C. Duties. The Commission shall:

- (1) Advise and assist the Governor in improving access to a continuum of mental-health services across the State;



- (2) Consider the findings of the Maryland Behavioral Health Advisory Council 2017 Strategic Plan: 24/7 Crisis Walk-in and Mobile Crisis Team Services;
- (3) Conduct regional summits in various parts of the State to study how mental illness may impact parts of the State differently;
- (4) Submit an interim report no later than six months from the date of this Executive Order on its findings relating to access to mental-health treatment services in the State; and
- (5) Submit **AN ANNUAL REPORT TO THE GOVERNOR ON OR BEFORE DECEMBER 31** [a final report to the Governor by December 31, 2019], that includes, but is not limited to, recommendations for policy, regulations, or legislation to address the following:
  - (a) Improving the statewide, comprehensive crisis response system; and
  - (b) Ensuring parity of resources to meet mental-health needs.

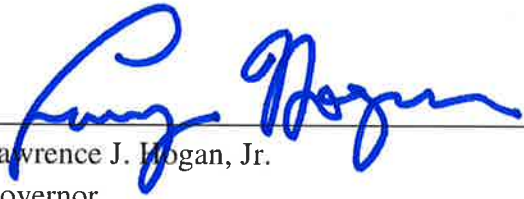
D. Procedures.

- (1) The Lieutenant Governor shall be Chair of the Commission. The Chair shall:
  - (a) Oversee the implementation of this Executive Order and the work of the Commission;
  - (b) Determine the Commission's agenda; and
  - (c) Identify additional support needs of the Commission.
- (2) The Commission shall convene within 90 days of this Executive Order and meet as frequently as necessary to satisfy the deadlines established herein.

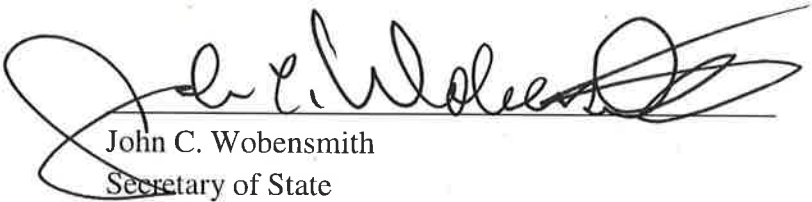
- (3) A majority of the Commission shall constitute a quorum for the transaction of any business.
- (4) The Commission may adopt other procedures as necessary to ensure the orderly transaction of business.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, effective this 28th Day of May, 2019.



  
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Lawrence J. Hogan, Jr.  
Governor

ATTEST:

  
\_\_\_\_\_  
John C. Wobensmith  
Secretary of State



THE MARYLAND GENERAL ASSEMBLY  
ANNAPOLIS, MARYLAND 21401-1991

April 29, 2019

Robert R. Neall, Secretary  
Maryland Department of Health  
201 W. Preston Street  
Baltimore, Maryland 21201

Dear Secretary Neall:

During the 2019 session, several bills related to the delivery of behavioral health care in the State were introduced in the General Assembly. House Bill 846 – *Maryland Medical Assistance Program – Managed Care Organizations – Behavioral Health Services* would have required managed care organizations, rather than the specialty behavioral health system, to provide or arrange for behavioral health services beginning January 1, 2021. In contrast, House Bill 938 – *Behavioral Health Transformation Act of 2019* sought to change the current delivery system for specialty behavioral health services into an at-risk service delivery system rather than the current fee-for-service system. After the House bill hearings and a Senate Finance Committee workgroup session, it became evident that the stakeholder community had not reached consensus on the issue and that such consensus would not be achieved within the 90 day legislative session. This is especially true in light of strict legal timelines for meeting critical behavioral health needs of many court-involved patients for whom any reformulated MCO system would be required to serve.

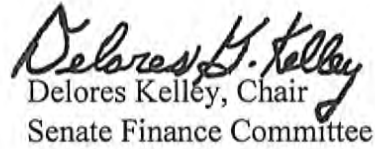
As chairs of the General Assembly committees with jurisdiction over the delivery of health care in our State, we recognize that any redesign regarding behavioral health services requires a thoughtful and deliberative process that is inclusive of stakeholders. We also recognize that any redesign of health care delivery must include consideration of the requirements of the Total Cost of Care Model. Therefore, we are requesting that the Department convene and lead an interim workgroup to examine and make recommendations on how the State should provide, administer, and finance behavioral health care in conjunction with the Total Cost of Care Model that increases the coordination and quality of somatic and behavioral health care for Medicaid enrollees, is cost-efficient, and promotes access to services. Additionally, the workgroup should consider and recommend whether behavioral health services should be offered through managed care organizations. We are further requesting that the Department provide the committees with a list of the members of the workgroup and allow open participation from stakeholders. Finally, the committees will be holding a briefing on the workgroup's findings and recommendations prior to the 2020 legislative session.

If you have any questions regarding this request, please contact Erin Hopwood, committee counsel to the House Health and Government Operations Committee at 410-946-5482 or Allison Taylor, committee counsel to the Senate Finance Committee, at 410-946-5367.

Sincerely,

A handwritten signature in blue ink that reads "Shane". The signature is fluid and cursive, with a large initial "S" and a trailing flourish.

Shane Pendergrass, Chair  
House Health and Government  
Operations Committee

A handwritten signature in black ink that reads "Delores G. Kelley". The signature is cursive and includes a large initial "D".

Delores Kelley, Chair  
Senate Finance Committee