Behavioral Health Care Treatment and Access Commission 2024 Report

Health General Article, Section 13-4807(a)

Maryland Department of Health

January 21, 2025

Introduction

During the 2024 legislative session, House Bill 1048 (HB1048), titled "Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access – Alterations," was adopted. The intent behind this Departmental legislation was to streamline efforts and maximize effectiveness of both the Behavioral Health Advisory Council (BHAC or Council) and the Commission on Behavioral Healthcare Treatment and Access (the Commission). Among other things, HB1048 allows for joint meetings and reporting between the two bodies. Moreover, it requires the Commission to make recommendations (in coordination with the Council) regarding Medicaid, including (1) the continuation of the State's behavioral health carve-out and (2) the financing structure and quality oversight necessary to integrate somatic and behavioral health services and ensure compliance with the federal Mental Health Parity and Addiction Equity Act. Such recommendations must be made by July 1, 2025.

In addition to HB1048, the Commission is also required by the 2024 *Joint Chairmen's Report* to examine intradepartmental and interdepartmental initiatives designed to address substance use disorder (SUD) among Marylanders. Specifically, as part of its annual reporting requirement the Commission must describe these initiatives and discuss their goals, associated costs, and plans by the Maryland Department of Health (MDH) to continue the efforts.

HB1048 took effect on July 1, 2024. Since its effective date, significant work has been undertaken to further integrate the work of the Council and Commission, including the individual mandates for each body, that predate the passage of HB1048.The individual mandates for both the Council and Commission are outlined below.

Mandate of the Behavioral Health Advisory Council. The BHAC was established in October 2015 under Health-General Article (HG) §7.5– 305. The BHAC is a forum for disseminating and sharing information concerning the Public Behavioral Health System (PBHS). The Council advocates for a comprehensive, broad-based, person-centered approach to providing social, economic, and medical support for people with behavioral health needs as mandated by Health-General Article § 7.5-305.

The Council, as a key player in the behavioral health sector, actively engages with state agencies to seek collaboration for improved behavioral health services. Its pivotal role in making recommendations to the state on the behavioral health plan and federal grant documents and applications, ensures that stakeholders are involved in the decision-making process.

The Council also diligently monitors, reviews, and evaluates the allocation and adequacy of behavioral health services and funding. Per Health-General Article, § 7.5-305, an annual report of the Council is due to the Governor at the end of each calendar year.

The Behavioral Health Advisory Council (BHAC) was established in October 2015 in Maryland under the Annotated Code of Maryland, Health General § 7.5-305, and Federal Public Law (PL) 102-321. The Council aims to:

1. Promote and advocate for planning, policy, workforce development, and services that ensure a coordinated and quality care system. This outcome-driven system integrates prevention, recovery, evidence-based practices, and cost-effective strategies to enhance behavioral health services across the State.
2. Advocate for a culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment, and recovery services. These services should support and foster wellness, recovery, resiliency, and health for individuals with behavioral health disorders and their family members.
3. Engage with various groups or commissions based on legislative priorities or the Administration's special projects, providing guidance and recommendations for the behavioral health system.
4. Monitor, review, and evaluate the allocation and adequacy of behavioral health services and funding per PL 102-321 at least once a year.
5. Review and recommend behavioral health plans, federal grant documents, or other application materials developed in compliance with applicable state and federal laws.
6. Consult with state agencies as needed to fulfill the duties of the Council.
7. Submit an annual report to the Governor per § 2–1257 of the State Government Article, the General Assembly on or before December 31 of each year.

The Council consists of 55 members. Among them, 28 are statutory Ex-Officio members or their designees, representing state and local governments, the judiciary, and the legislature. The Secretary of the Maryland Department of Health (MDH) also appoints 13 members to represent behavioral health providers and consumer advocacy groups. The remaining 14 members represent consumers, family members, professionals, and the community. A complete list of council members can be found in Appendix 1.

The BHAC's membership must provide a balanced representation of mental health and substance use disorders and cover various geographic regions of the State. The current membership reflects diverse ethnicities, races, genders, cultures, age groups, and languages, including American Sign Language.

Mandate of the Commission on Behavioral Health Treatment and Access. Chapter 291 of 2023 (Behavioral Health Care - Treatment and Access (Behavioral Health Model for Maryland) established the Commission on Behavioral Health Care Treatment and Access at the Maryland Department of Health (MDH), set to sunset in 2027. In 2023, Dr. Laura Herrera Scott, Secretary of Health was appointed by the Governor, the President of the Senate, and the Speaker of the House to chair the Commission. The other 37 members to the Commission were selected based on the criteria in the law. A full listing of Commission members is included in Appendix 2.

The purpose of the Commission is to make recommendations to provide appropriate, accessible, and comprehensive behavioral health services that are available on demand to individuals in the State across the behavioral health continuum. Specifically, the Commission’s founding statute tasked the group with the following responsibilities:

1. Conduct an assessment of behavioral health services in the State to identify needs and gaps in services across the continuum, including community–based outpatient and support services, crisis response, and inpatient care;
2. Examine the methods for reimbursing behavioral health care services in the State and make recommendations on the most effective forms of reimbursement to maximize service delivery;
3. Compile findings of State–specific needs assessments related to behavioral health care services;
4. Review recommendations and reports of State commissions, workgroups, or task forces related to behavioral health care services;
5. Conduct a needs assessment on the State's behavioral health care workforce to identify gaps and make recommendations to ensure an adequate, culturally competent, and diverse workforce across the behavioral health care continuum;
6. Review trends and best practices from other states regarding policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care;
7. Examine and make recommendations related to the behavioral health of the geriatric and youth populations in the state;
8. Examine and make recommendations to provide appropriate and adequate behavioral health services to individuals with developmental disabilities and complex behavioral health needs, specifically youth;
9. Assess the health infrastructure, facilities, personnel, and services available for the State's forensic population and identify deficiencies in resources and policies needed to prioritize health outcomes, increase public safety, and reduce recidivism;
10. Make recommendations on expanding behavioral health treatment access for the State's court–ordered population;
11. Make recommendations on action plans regarding the behavioral health care system's capacity to prepare for and respond to future challenges affecting the entire State or particular regions or populations in the State, including pandemics and extreme weather events;
12. Make recommendations to ensure that behavioral health treatment is provided in the appropriate setting, including methods to divert behavioral health patients from emergency departments by using the Maryland Mental Health and Substance Use Disorder Registry and Referral System established under § 7.5–802 of this article and 2–1–1;
13. Examine and review the use of harm reduction strategies to facilitate access to care; and
14. Examine methods to assist consumers in accessing behavioral health services.

As discussed earlier in this report, the Commission's mandate was expanded some during the 2024 legislative session, adding additional reporting requirements amongst other things.

Joint Accomplishments. In its first six months of meeting jointly, the Commission and Council, met three times with opportunities for stakeholder input at each meeting.[1] Through these three meetings, and additional meetings of associated workgroups and subcommittees, the following key tasks were undertaken:

1. Reviewing recommendations and reports of State Commissions, Workgroups, or Task Forces related to behavioral health care services;
2. Assessing behavioral health services in the State to identify needs and gaps in services across the continuum, including community-based outpatient and support services, crisis response, and inpatient care;
3. Compiling findings of the State-specific behavioral healthcare needs assessments;
4. Reviewing trends and practices from other states regarding policy and reimbursement strategies that ensure quality of care and access to a comprehensive array of services; and
5. Addressing council-specific mandates related to the Behavioral Health Administration (BHA) State Plan as required by the Substance Abuse and Mental Health Services Administration (SAMHSA).

In addition to these areas, the Commission and Council undertook activities to align the activities of its respective workgroups and subcommittees. The Commission's statute mandates that four workgroups be established, hold meetings, and report back to the full Commission. These workgroups are: (1) Geriatric Behavioral Health; (2) Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs; (3) Criminal Justice- Involved Behavioral Health; and (4) Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing. There were five existing BHAC workgroups: (1) Planning; (2) Children, Adolescents, and Young Adults; (3) Recovery Supports; (4) Criminal Justice; (5) Cultural and Linguistic Competency. Two of these workgroups have been aligned with the mandated Commission workgroups: (1) the Children, Adolescents, and Young Adults workgroup was aligned with the Commission's Youth Behavioral Health, Individuals with Developmental Disabilities and Individuals with Complex Behavioral Health Needs; and (2) the Criminal Justice workgroup was aligned with the Commission's Criminal Justice-Involved Behavioral Health workgroup. Two BHAC workgroups, the Planning Committee and Cultural and Linguistic Competency Committee, still meet independently.

This report is organized into six sections. First, the report reviews prior recommendations and reports related to behavioral health care services that have been issued in the past year. It also summarizes the report required by the 2024 *Joint Chairman Report* related to conducting an overdose inventory. Second, the report contains an updated behavioral health needs assessment based on the most recently available claims from the public behavioral health system.The third section of this report summarizes the Commission/Council's progress in examining the state's behavioral health carve out, as it builds towards recommendations in calendar year 2025. It also discusses how this work meets the Commission's mandate in reviewing trends and best practices

[1] In addition to the three joint meetings that were held, the BHAC also met separately in January, March, and May, and the Commission met separately one time (May).

from other states regarding policy and reimbursement strategies that support access to a comprehensive array of services and ensure quality of care. The fourth section of the report discusses work on the Behavioral Health State Plan, a federal mandate for the Behavioral Health Advisory Council. The fifth section of this report provides a summary of the Commission and Council's meetings in 2024. The final section outlines work done by the four statutorily mandated workgroups for the Commission, and workgroup activities of the Council.

Part 1: Review of Prior Recommendations and Reports

The authorizing statute for the Commission requires the body to review prior recommendations and reports of State Commissions, Workgroups, or Task Forces related to behavioral health care services. In 2023, the Commission conducted a thorough review and synthesis of prior report findings for the Commission's review; for a full analysis of this review, please see the 2023 Behavioral Health Care Treatment and Access Commission Report.[2] While a comprehensive analysis occurred the prior year, the Commission and Council continued to review newly published behavioral health reports. During Commission and Council meetings in 2024, the Commission/Council and its Workgroups received several presentations discussing reports for the edification of the group.

These reports included the:

- Maryland Health Care Commission's *Behavioral Health Workforce Study*;[3] and
- Findings on Strategic Implementation of State Resources for Opioid Response, as required by the 2024 *Joint Chairmen's Report*.

Behavioral Health Workforce Study. The Maryland Health Care Commission's (MHCC) *Behavioral Health Workforce Study* explored a comprehensive needs assessment for the behavioral health workforce in the State. During the May 2024 Commission meeting, the Commission received information on a demographic analysis of the State's behavioral health workforce and an examination into the current unmet need for behavioral health services. The report noted examples of workforce investment funds in other states. During their October 2024 meeting, the Behavioral Health Workforce Development, Infrastructure, Coordination and Financing Workgroup received an updated presentation on the finalized report which elaborated upon behavioral health workforce trends and discussed avenues through which the workforce gap can be addressed.

Findings on the Strategic Implementation of State Resources for Opioid Response. MDH is required by House Bill 1148 (Chapter 291, 2023) and Senate Bill 582 (Chapter 290, 2023) to

[2] The 2023 Behavioral Health Care Treatment and Access Commission Report is available at https://dlslibrary.state.md.us/publications/Exec/MDH/HG13-4807_2023.pdf. The Report discusses the comprehensive review of prior reports in Part I. Appendix C includes a list of all prior reports reviewed by Commission staff.

[3] The Maryland Health Care Commission's Behavioral Health Workforce Study is available at https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/documents/presentations/2024/20240620/agd8_bh_workforce_needs_assessment_briefing.pdf.

provide a report to the Commission on Behavioral Health Care Treatment and Access on January 1 of each year. The subject of this report is based on both the initial HB referenced, but also any additional information requested by the Commission. In 2024, it was determined that the budget committees were interested in understanding the range and effectiveness of strategies MDH is implementing to address the opioid overdose crisis. Specifically, the *Joint Chairmen's Report* required the Department to include a list of department wide and interdepartmental initiatives designed to address substance use disorder among Maryland residents. This includes statewide efforts managed by MDH and be inclusive of preventive, educational, recovery, and other relevant supportive services and programs. A full inventory that is responsive to the *Joint Chairmen's Report* requirements is included in Appendix 3.

To meet this mandate, MDH compiled a list of initiatives it has funded and outlined additional details on the scope and history of these initiatives from the offices and sponsors responsible. These details were compiled and analyzed by BHA staff and reported in both document and presentation form. The analysis includes a five (5) year look back from FY2020-FY2024 and included sources of funding, including but not limited to: state general funds, special funds, and federal funds such as State Opioid Response (SOR) and Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS).

Of note, there were nearly 1,000 initiatives reviewed with estimated investments of approximately $400,000,000 over five (5) years. The initiatives, which often include both mental health and substance use disorder services, reflect the continuum for prevention and promotion, primary behavioral health and early intervention, and treatment and recovery. Programs are represented across the lifespace as well as reflective of partnerships with other State agencies.

The inventory allowed for the identification of a number of key takeaways such as:

- Service delivery gaps in programs and funding identified for Eastern and Western Maryland
- Additional coordination within and across initiatives is critical
- A demonstrated need to continue to braid and blend funding
- Identify additional pathways for reimbursement for services
- Disparities across all sectors need to be analyzed and addressed
- Incorporate strategies for addressing the social drivers of health
- Greater linkage between behavioral health and somatic health care
- Increase awareness of the opioid crisis, including stigma reduction
- Focus on enhancement of peer workforce, and
- Establish measures for equity and outcomes

Regarding next steps, a detailed analysis of the inventory, contrasting it with the "White Space Analysis," which mapped access to public behavioral health services by jurisdiction, will be undertaken. BHA will also look to develop and partner to implement interventions for specific populations such as men of color, youth, and LGBTQ populations. BHA will also seek to enhance care coordination opportunities and foster further integration between healthcare providers and behavioral health providers. Additional critical initiatives will also look to explore

supporting families and youth in accessing treatment and post-treatment aftercare and continue to identify opportunities to reduce stigma and access to care.

Part 2: Needs Assessment

The Commission is required to conduct an assessment of behavioral health services in the State to identify needs and gaps in services across the continuum of care, including community-based outpatient and support services, crisis response, and inpatient care. The Commission is also required to compile findings of this assessment.

This information was provided in the Commission's first report to the General Assembly in January 2023. However, the Commission and Council undertook activities to update this assessment using more recent data. The needs assessment presented in this section contains four components:

- An analysis of morbidity and mortality data as it relates to behavioral health, including a summary of newly presented data from Maryland's Overdose Dashboard;
- An analysis of adult utilization data for the public behavioral health system;
- An analysis of children's utilization data for the public behavioral health system; and
- An assessment of currently funded services.

Key findings from the updated needs assessment is presented in this section. This updated assessment is necessary to further understand gaps in behavioral health care in our state, and identify areas where progress has been made in improving access to care. Additional analysis will continue to be conducted by the Commission and Council annually as new claims data becomes available. This information was assessed and analyzed within the context of a behavioral health continuum of care (Figure 1).

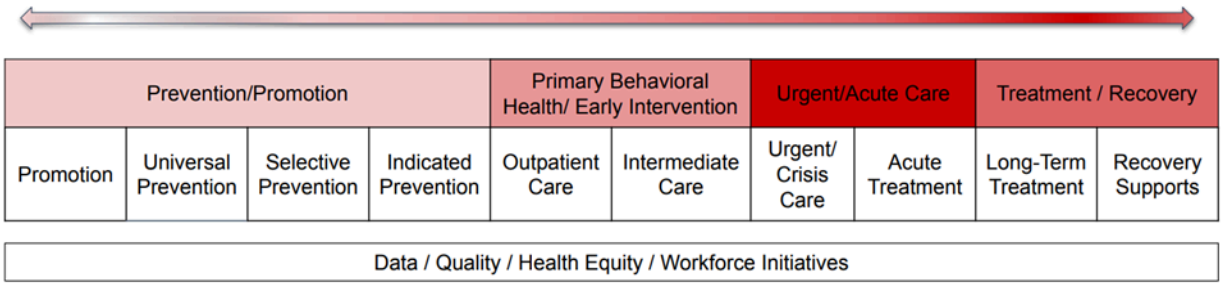

Figure 1. Behavioral Health Continuum of Care

Morbidity and Mortality Data. Untreated behavioral health conditions have serious consequences, including reduced life expectancy. There were 610 deaths due to intentional self-harm (suicide) in 2022 down 2.7% from the prior year. The age-adjusted mortality rate for suicide was 9.5 per 100,000 population in 2022, 3.0% lower than the 2021 rate of 9.8 per

100,000 population.[4] In 2023, there were 2.5% fewer fatal overdoses in Maryland compared to 2022 (decreasing from 2,576 to 2,511). There were 1,776 fatal overdoses in the 12 months ending in October 2024. This was a 30% decrease compared to the 12 months ending in October 2023, when there were 2,605 fatal overdoses in Maryland.

As part of the Department's comprehensive effort to combat the overdose crisis, it launched a new tool in July 2024: the Maryland Overdose Data Dashboard. A presentation on this new tool was provided to both the Commission and Council at their respective May meetings. The dashboard provides easy-to-understand visualizations of overdose trends; to help partners throughout Maryland reach the most affected communities. It combines timely data on fatal overdoses, non-fatal emergency department visits, and EMS naloxone administrations. It also provides historical trends and insights across age, race and gender for proactive monitoring and targeted overdose response.

The Maryland Overdose Data Dashboard includes the following features:

- **Unified Data:** The dashboard combines data on fatal overdoses, non-fatal emergency department visits, and EMS naloxone administrations. Users can search this data by zip code.

- **Timely Data Updates:** The dashboard provides the most current data available, reducing the data release period from 90 to 30 days. This allows for more proactive monitoring and response.

- **Historical Trend Analysis:** The dashboard provides historical data at the jurisdictional level, enabling the analysis of community trends over time.

- **Demographic Insights:** The dashboard provides insights across age, race and gender for targeted overdose responses across jurisdictions.

Analysis of PBHS claims for Adults. The Commission and Council analyzed public behavioral health system (PBHS) claims for fiscal year 2023.[5] Claims data was broken out into two categories: (1) mental health, and (2) substance use disorder services. Several key findings were noted:

- **Billing providers.** Consistent with findings from the Commission's prior work, there are fewer providers billing for SUD treatment services than mental health services. During FY23, 1,125 distinct providers submitted SUD claims for adults age 18 and older and 2,295 distinct providers submitted adult mental health services claims.

[4] Data from the MDH Public Interactive Overdose Dashboard and the Vital Statistics Administration 2022 Annual Report.

[5] This data is for all "active" billing Maryland Public Behavioral Health System (PBHS) providers who submitted a claim for services rendered in Fiscal Year 2023. The data are based on ASO-OPTUM claims paid through 10/31/2024. Data is un-duplicated within each provider for the number served-by service category.

- **Regional disparities.** We continue to observe that a full continuum of care does not exist in many parts of the state. A disproportionate number of providers are located in the Baltimore metropolitan region, with fewer providers in the Western, Eastern, and Southern parts of the state. Approximately 45% of mental health and substance use disorder providers who submitted claims were from Baltimore City and Baltimore County.
- **Outpatient services.** Outpatient services continue to be the most commonly used mental health and SUD services. For mental health, approximately 167,000 individuals accessed outpatient services, representing 93% of all mental health service users. For SUD service users, approximately 50,600 individuals, representing 48% of all SUD service users, accessed outpatient services.

Analysis of PBHS claims for children and youth. The Commission and Council also analyzed PBHS claims for fiscal year 2023 for children and youth under the age of 18. Similar to the analysis for adults, claims were broken out as they relate to SUD and mental health. Several key findings were noted, which are consistent with findings from the prior year:

- **Psychiatric rehabilitation and support services.** Among the services studied, psychiatric rehabilitation services, which provide rehabilitation and support services to aid in the development and enhancement of independent living skills, was the second most utilized service after traditional outpatient services.
- **Limited Access to Intensive Community-based Services.** Few children and youth with intensive behavioral and emotional challenges are accessing community-based behavioral health services, including intensive care coordination and in-home programs.
- **Differences in utilization exist between boys and girls.** Findings show that compared to males, females are more likely to enter services in the teen and young adult years and are more likely to use inpatient hospital and Emergency Department services.
- **Regional disparities.** In many parts of the state, a full continuum of care does not exist. All jurisdictions, except Charles, Howard, Montgomery, Prince George's, and St. Mary's had PBHS service use rates that were higher than the state average of 131.6 per 1,000 eligible. Three jurisdictions (Charles, Montgomery, and Prince George's Counties) had utilization rates of less than 100 per 1,000 eligible).

Currently Funded Services. Using the continuum as a framework, the Commission and Council assessed currently funded services across Maryland's 24 jurisdictions. Key findings indicate that there are a number of services paid for in the PBHS that are covered by Medicaid. Specifically, services with limited availability include detoxification, partial hospitalization, and mental health residential treatment. There is also limited availability for children's services, such as Targeted Case Management, Residential Treatment Centers, Respite, and Inpatient SUD Services.

Changes From the Prior Needs Assessment. The Commission and Council noted that there were some key changes from the needs assessment conducted from the prior year. Specifically, those changes are as follows:

- **Inpatient MH Services.** In FY22 Caroline County did not have any providers billing for this service within its jurisdiction, while they did in the FY21 claims dataset.
- **Inpatient SUD Services.** In FY22 Calvert, Caroline, Charles, and Dorchester counties did not have any providers billing for this service within their jurisdiction, while they did in the FY21 claims dataset. However, preliminary analysis of FY23 claims shows that both Charles and Calvert counties now have providers billing for these services.
- **Residential SUD Treatment.** In FY22, Caroline and Worcester counties added new providers billing for this service within their jurisdictions, while they had no providers billing for this service in the FY21 claims dataset.
- **1915(i) services for children and youth.** In FY22, St. Mary's County added a provider billing for this service within its jurisdiction, while they had no providers billing for this service in the FY21 claims dataset.

Efforts to Fill the Whitespace. Notably, the state has made progress in meeting unmet needs in the state through a few key initiatives. This includes:

- Mobile Crisis Teams & Behavioral Health Crisis Stabilization Centers. Final regulations went into effect May 27, 2024. To date, five Mobile Crisis Team providers are licensed and enrolled in Medicaid across 14 jurisdictions and BHA is working with additional providers. Additionally, the Administration invested more than $13 million in a pilot program to expand and improve these services across the state.
- Children, Adolescent, & Family Roadmap: The Behavioral Health Administration partnered with the Maryland Coalition of Families to develop a roadmap for strengthening the public behavioral health system to better meet the needs of Maryland children, you, and families, prioritize equity, and strengthen access to and quality of home and community-based care. Building upon work already underway, the Roadmap with set forth a vision for the PBHS, as well as goals and specific strategies to achieve this vision
- Bed Registry and Referral System. In alignment with 2021 House Bill 1121, MDH/BHA developed requirements and issued a Request for Response for a vendor to develop and manage a statewide behavioral health service management platform. The platform will include a searchable inventory of behavioral health providers including inpatient, crisis, and outpatient services; the capability for providers to update the availability of services in real-time; an electronic referral system to facilitate electronic referrals to mental health and substance use disorder providers; and a care traffic control platform to deploy mobile crisis response and stabilization services.

Part 3: Progress in Examining State's Behavioral Health Carveout

In its first six months of meeting jointly, the Commission and Council laid initial groundwork to examine the state's Medicaid behavioral health carveout during its first two meetings. Among other things, this work also included initial examination of models used in other states, part of the Commission's initial statutory mandate.. This work was largely supported by Health

Management Associates (HMA), offering national expertise in trends and outcomes as it relates to behavioral health integration.

Meeting 1. The Commission and Council focused their first joint meeting on starting the conversation regarding this new reporting requirement. This included a brief history of Maryland Medicaid's Behavioral Health ASO Model (see Appendix 6).

The Commission/Council also received a primer on behavioral health managed care model options, including an overview of model options used across 44 states:

- Carve in of behavioral health services into comprehensive, capitated MCO contracts (a set payment amount for each enrollee regardless of the number or type of visits)
- Contract with risk-based limited benefit prepaid specialty health plans (PHPs) (health plans are paid per-member-month to cover a limited set of services)
- Retain the FFS model but contract with public or private Administrative Service Organizations (ASOs) to deliver behavioral health services on a non-risk basis
- Maintain some services in a FFS payment model without contracting with an external vendor to provide administrative oversight

HMA largely focused on outcomes resulting from integration of behavioral health and somatic health benefit management. Professional and academic literature generally support integration as the most effective way of providing clinical services and managing behavioral health financings. However, administering effective integrated systems of care requires several intermediary steps, and there are a variety of strategies and structures that may be appropriate for Maryland.

Based on current academic literature, HMA identified five necessary activities for integrated behavioral health benefit management that were presented to the Commission and Council for consideration. Each activity had corresponding strategies that were derived from professional and academic literature on the topic of behavioral health outcomes:

(1) **Clear articulation of policy and operational goals and capacity to carry out implementation.** A key strategy in this area includes clearly reflecting the state's policy goals, and allowing managed care plans the space to develop innovative approaches, with an explicit focus on: continuity of care requirements; requirements related to sub-contracting and coordination among entities; multi-system care coordination and beneficiary protections; and flexibility for plans to modify program elements to best meet beneficiary needs. An additional strategy includes requiring increased expertise around behavioral health populations and collaboration with providers amongst primary care, health plans, and Medicaid agencies to prevent inefficient processes when transitioning policy and oversight of certain services.

(2) **Stakeholder engagement.** A few key strategies related to this activity were offered. This includes, investing in strong state capacity for provider relations, focusing on ensuring stakeholder collaboration and partnerships for developing the model, and engaging diverse perspectives across several stakeholder groups.

(3) **Provision of fiscal incentives for providers.** Key strategies for this activity were offered in four areas. This includes providing financial incentives, such as providing incentives for primary care to provide behavioral health screening, and coverage of non-traditional behavioral health services. Incorporating support or financial incentives for practice transformation, as well as combining financial integration with investments in workforce recruitment and training for both primary care and behavioral health providers were also discussed. Finally, offering succinct incentives and expectations for health plans as it relates to payment and risk was identified.

(4) **Balance network management with collaboration with MCOs (and providers)**. A number of strategies were offered for consideration. Among other things, this included communicating clear expectations on penalties, rewards, and who is responsible for delivering covered services. Other effective strategies include defining clear regulations and administrative processes, scheduling systemic check-ins with health plans, ensuring an adequate provider network(s), collaborating with MCOs on provider training activities, and strengthening contracting and data analytics expertise.

(5) **Identify metrics to assess improvements in healthcare access, quality, and outcomes.** The key strategy identified in this area was to incorporate clear process and outcome reporting metrics, such as those related to utilization of services (i.e., inpatient, outpatient, primary care, emergency department), readmissions after hospitalizations, total costs for beneficiaries with serious mental illness, total spend for beneficiaries who have chronic conditions as well as behavioral health diagnoses, mental health screening and follow up, follow up with behavioral health providers after a behavioral health hospitalization, and various factors related to social determinants of health (e.g., rates of arrest, employment, housing status). Examples of metrics from other states (Florida, Kansas, and Arizona) were also identified.

Survey Responses. Following the July Commission meeting, discussion questions that were developed by HMA were distributed via survey to Commission, Council members and members of the public. Responses to these questions have been summarized below.

Question 1. We've outlined five necessary steps for integrated behavioral health benefit management. Are we missing any critical steps?

One item that was suggested by many individuals—specifically by many members of the public—was to develop a core set of goals and values that will guide behavioral health system reform and that align with the goals and mission of the state. Similarly, many people emphasized the importance of developing a clear plan for implementation of new systems, as well as a way to monitor and adapt the implementation plan as necessary. Together, these two items add additional insight into the first step outlined by HMA in their presentation: "clear articulation of policy and operational goals and capacity to carry out implementation." An additional theme throughout the answers to these questions was the importance of compliance and accountability. Individuals suggested instituting financial and quality assurance roadmaps, underscored the importance of compliance with the Mental Health Parity and Addiction Equity Act, and recommended provider/stakeholder accountability mechanisms. One member of the Behavioral

Health Advisory Council specifically encouraged "more accountability for providers through payment structures like [Value-Based Purchasing], [Certified Community Behavioral Health Clinics], capitation" and other such mechanisms.

Question 2. What are the strengths and challenges of the current behavioral health ASO model in Maryland?

One vital strength of Maryland's current ASO model that was made evident in the survey responses is the partnership and coordination afforded by the system's centralized administration. Many individuals expressed how they appreciate the system's uniform processes for providers. A related strength is the centralized administration which should allow for ease of data sharing and aggregation. Challenges noted by the group included the fact that data sharing and outcomes measurement are not conducted or communicated effectively in practice. Many people also indicated that the current ASO model has an untimely and complicated reimbursement process, limited quality oversight, issues mitigating fraud/waste/abuse, and fails to meet the needs of many minority consumers. The most frequently mentioned challenge was that the current model does not promote integration of behavioral health with somatic health care. One Commission member noted that this lack of integration contributes to poorer health outcomes compared to a more integrated model.

Question 3. How might a different behavioral health management model address the challenges of the current system?

Similar to the previous question, many individuals indicated that they would like to see a model that would allow for greater integration of behavioral health care with somatic health care. One member indicated that an integrated model could help specifically to improve health quality and outcomes while also reducing costs through coordination. Other ways in which a different model could address current challenges include increased accountability mechanisms for providers and a reduction in financial mismanagement, as well as better data sharing/collection and improved outcome measurements. Several members of the public also mentioned that, in a new model, they would like to see local behavioral health authorities (LBHAs) involved to a greater extent and for them to have a greater amount of authority.

Question 4. If the State were to consider changes to the current ASO model, what would be the major changes to implementing a different model?

Two main changes that would be required would be greater stakeholder buy-in/engagement and development of goals for the new model. A member of the public indicated that they felt it was premature to consider changes to a new model without first considering stakeholder engagement and goal setting. Examples of stakeholder engagement mentioned in the responses included receiving input from providers about desired changes in a different model, as well as inclusion of diverse stakeholders to ensure that the needs of all communities are being met in the new model. Several individuals indicated that they would like to see that the State and the state's providers have the capacity for widespread system change prior to a change being made. Other changes

mentioned include greater LBHA involvement, legal and regulatory changes, and possible changes to the way rates are set for services.

Question 5. What role would your agency or organization play in implementing a different model, and how would this impact your current operations?

The responses to this question varied greatly depending on the location and the scope of the work being done by the individual responding. Some individuals indicated that they were unsure of how they or their organization could support the implementation of a new model. Others stated that they could assist with the provision of technical assistance to providers regarding new changes. Many indicated that a new model would cause widespread changes to the current operations of their organizations, but said that they felt they could alter their operations accordingly to cooperate with a new model. For the better part, the responses were supportive of the implementation of a different model.

Meeting 2. The second discussion on Maryland's behavioral health model, held at the September 2024 Commission/Council meeting offered a more robust overview of the state's current behavioral health administration model, including factors contributing to the current model, and strengths and challenges of the current ASO model, as well as discussing integrated models used in other states.

Currently, MDH contracts with an ASO to manage behavioral health benefits for Medicaid and state-funded non-Medicaid behavioral health services. HMA presented a variety of factors contributing to the current model. Among other things, this includes:

- Providers and advocates have expressed concerns that integrating behavioral health services into the MCOs might lead to reduced access for those in need.
- Many providers find the ASO model to be simpler and more straightforward when it comes to reimbursement.
- Maryland has followed the same approach for a long time and transitioning to a new or different structure could be challenging.
- The willingness and capacity for change have contributed to the continuation of the current model.
- Integrating services into the MCOs would require additional state staff to oversee behavioral health benefits across multiple MCOs.
- There is a need for a clear, shared definition of what an integrated model would look like, whether in terms of administrative functions or clinical integration, and how it could truly benefit the system.

HMA also outlined several strengths and challenges of the current model. Areas of strength that were identified include that the current model:

- Reduces administrative burden for providers by offering a single, streamlined system, regardless of member eligibility.

- Ensures continuity of care for members transitioning between Medicaid and non-Medicaid services without needing to change providers.
- Allows one entity to combine state funding with Medicaid dollars for reimbursement.
- Enables the ASO to detect duplicate or overlapping services and provide additional support to members when needed.
- The ASO model can more easily facilitate the implementation of new or enhanced behavioral health programs through a single entity.
- Simplifies efforts to improve payment processes for behavioral health providers by working with one entity

Challenges related to the existing ASO were also presented:

- Challenging to provide care coordination between physical and behavioral health systems.
- Integrated care goals are not being met through the current requirement MCO and ASO's sharing data/information
- Provider challenges with determining correct payer in different care and treatment centers
- Mental health and addictions parity analysis is more difficult to assess across different systems
- It is more difficult to provide cross-system incentives for improved care in a carved-out system

The Commission and Council were also presented with three potential integrated behavioral health models to explore, as well as examples of states that offer such models. It is important to note that there are challenges and strengths with models used in other states, which HMA discussed at a high level. Examples of models used in other states were presented, including:

(1) **An integrated model with current MCOs.** Under this model MDH would contract directly with MCOs for Medicaid behavioral health benefits, removing the need for an ASO in the administrative structure. Such a model would be similar to Kansas and Washington, among other states. MCOs would establish contracts with behavioral health providers to form their networks. MDH would need to decide whether MCOs will manage non-Medicaid behavioral health funds or if a separate ASO or alternative process is necessary for administering those funds. MDH would oversee the behavioral health benefit administration for the nine MCOs. However, most MCOs subcontract their behavioral health services, which poses challenges for achieving integrated care.

(2) Hybrid model for MCOs and a centralized ASO. Under this model, MDH maintains the contract with the ASO and requires the MCOs to contract with the ASO for administration of behavioral health services for the Medicaid member. Maryland could look to states including New York, Texas, and New Jersey for examples of potential model designs. Providers continue to contract with the ASO- this is one of the significant differences from full carve-in. The ASO will manage the non-Medicaid BH funds. MDH would maintain oversight of the ASO.

(3) Specialized managed care plans. Under this model, a specialty plan coordinates care for individuals with complex behavioral health needs. This would be in addition to Maryland's current managed care offerings. Under this model, individuals with mild behavioral health conditions would continue to receive both behavioral and somatic services under the state's existing managed care organizations, while those with severe conditions would receive both their physical and behavioral health from a specialty plan. Maryland could look to Arizona, Florida, or Ohio for examples of such specialty plans, which typically exist for those with serious mental illness, or youth with complex behavioral health needs. It provides access to a network of mental health professionals and treatment programs as well as physical health services, and offers specialized care management and targeted interventions. In this model, the plan integrates behavioral health services within a managed care framework with the goal of managing costs while delivering comprehensive behavioral health care.

Survey Responses. At the end of this presentation, HMA posed seven discussion questions for Commissioners and Council members. After the joint meeting, a survey was issued to Commissioners, Council members, and members of the public. Each question, and a summary of responses received is offered below.

Question 1. What "core" goals and values are needed to support an effective managed care model?

Many individuals indicated that an effective managed care model should, most importantly, be patient-centered. As part of this value, the managed care model should be culturally responsive, linguistically accessible, and should have reduced barriers in eligibility requirements and coverage limits. One individual wrote in their response that an effective MCO should "provide providers with flexibility and efficiency to make recommendations based on their patient's needs and decrease the red tape required to obtain authorizations." Many responses emphasized the importance of accountability, transparency, and communication with stakeholders. Other frequently mentioned goals and values included integration of behavioral health and somatic care, competitive procurement of MCOs, prohibiting sub-carve out, and having accurate and usable data for outcome measures.

Question 2. How would you define an inclusive process for stakeholder engagement?

Open communication, as well as emphasis on layered and persistent engagement strategies, were among the common responses to this question. Individuals suggested that invitations be extended to stakeholders—especially those with experience in a managed care arrangement—to participate on committees, provide feedback on policies, and engage in open, transparent meetings where they can share their experiences. Further, it should be evident that stakeholder participation and input are highly valued. One member of the Commission stated, "[the] State needs to ensure that the process is undertaken without a pre-determined outcome; stakeholder input must be valued and given meaningful consideration with revision to the plan as

warranted." Several Commission members also suggested changes to the format of the Commission meetings to facilitate better stakeholder engagement.

Question 3. After hearing the last two presentations at the Commission meetings, what essential model components may improve the integration of behavioral and somatic healthcare?

A necessary component of an integrated model, according to the responses, would be to prioritize informed care coordination through effective real-time data sharing. Individuals suggested accomplishing this via a shared electronic medical record (EMR) platform or by improving the use of CRISP—the Chesapeake Regional Information System for Our Patients—in behavioral health practice. Several members of the Commission also suggested using Healthcare Effectiveness Data and Information Set (HEDIS) performance measures to incentivize clinical integration. Other responses suggested using existing clinical integration models, such as health homes and Certified Community Behavioral Health Clinics (CCBHCs), as a guide for informing integration efforts.

Question 4. What mechanisms should the State implement to support providers in maintaining financial viability and improving quality outcomes?

In order to both maintain financial viability and improve quality, many individuals suggested instituting value-based payments to reward providers who achieve targeted outcomes. Other common suggestions included an effective compliance pipeline, implementation of CCBHC models as safety net providers in each jurisdiction, coverage of measurement-based care coding in ASOs, and technical assistance programs for providers. Finally, several individuals reinforced the importance of being led by core values.

Question 5. How can the State enhance data collection and sharing between the State, MCOs, ASO, LBHAs, providers, and other partners?

The implementation of a centralized data collection platform will allow for ease of data collection and sharing. According to the survey responses, the State can expand upon this further by enforcing uniform data reporting requirements and incentivizing collection and use of patient-reported outcome measures. One individual elaborated upon this idea in their response and highlighted the importance of being open to change, sharing that "willingness of these groups to be open, learn, and collaborate for the good of the patient and family" would be vital for improving the data collection process. Several individuals also suggested a partnership with CRISP, which would facilitate data sharing and collection, as well as a State-convened learning community that has appropriate authority and capacity to guide the use of CRISP and resolve bugs when necessary. Further, the responses indicated that the State should implement best practices and recommendations from the current bidirectional data exchange, which can help facilitate effective data sharing.

Question 6. Given current workforce shortages in behavioral health, what steps could be taken to address providers' concerns about maintaining sufficient staffing levels?

Common responses to this question involved measures that would incentivize individuals who are entering the workforce to pursue a career in behavioral health. These measures included recruitment at educational institutions, tuition reimbursement/loan forgiveness, competitive compensation, and streamlined licensure and certification requirements. Individuals also mentioned competitive compensation for staff within the behavioral health workforce, as well as approval of cross-state services and licensure. Suggested measures for prioritizing quality of care while addressing workforce shortages included targeted rate enhancement with performance expectations, prioritization of performance-oriented policies, and utilization of the prospective payment system (PPS) methodology.

Question 7. What processes do you recommend for protecting individuals and families receiving services and to ensure that individuals may equitably access behavioral health services through the managed care models?

Responses to this question shared similar themes with that of previous questions in the survey, including measurement-based care, performance incentives, CRISP uptake, and the use of CCBHCs. Other suggestions included ensuring compliance with federal and state parity laws, as well as balancing utilization management while providing access to services with oversight by MDH. The most common answer emphasized the importance of inclusion and transparency for ensuring equitable access to behavioral health services.

Part 4: Review of the Behavioral Health Administration FY 25-27 State Strategic Plan

A key area that the Council and Commission focused on this year relates to BHA's State Plan. The State Plan is submitted to SAMHSA as a requirement for receiving federal funding through Mental Health Block Grants (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG). In this plan, BHA must explain how funds will be used to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances. BHA must also explain how funds will be used to prevent and treat substance use and promote public health.

Pursuant to Title 42 US Code Chapter 6A, Subchapter XVII, Part B, subpart i: section 300x–4(a) the Council is responsible for reviewing plans provided to the Council and for submitting to the State any recommendations of the Council for modifications to the plans. The Council reviewed the proposed State Plan in July 2024 with BHA staff incorporating comments and reorganizing the draft to highlight the priority focus areas, innovative programs, and the data driven mission. BHA presented the updated State Plan draft to the BHAC Planning Committee in August 2024 and then incorporated written and verbal feedback from Council members. BHA presented the proposed State Plan to the full Council and Commission in November. The State Plan will be posted for public comment in the coming weeks. The Council's leadership also participated in Federal Block grant planning and grant progress meetings with the Administration, which enriches our partnership and enhances our advisory role. The Council values the opportunity to offer procurement input and advocate for the involvement of local entities and consumer voices.

Part 5: Overview of Meetings

Prior to the implementation of HB1048, the Council met individually three times in 2024 on January 16, March 19, and May 21. The Commission met individually once on May 29. The Commission and Council held three joint meetings in 2024 on July 16, September 17, and November 19. Presentations given to Commission and Council members at each of these meetings can be found on their respective websites.

Meetings of the Behavioral Health Advisory Council.

Meeting 1 – January 16, 2024

During the Council's first meeting of the year, members of the Council received a Director's Report with updates on the current efforts of BHA, including a vision for a behavioral health continuum of care and behavioral health model legislation. Members of the Council also received updates on the efforts to align the Council with the Commission, and they learned about the Commission's statutorily-mandated workgroups, charges, and next steps.

The meeting continued with announcements and the approval of the minutes from the previous meeting. It then proceeded with a presentation on Problem Gambling Awareness, which discussed the mission and key accomplishments of the Maryland Center of Excellence on Problem Gambling, as well as the ways in which the Center can assist MDH efforts with technical assistance for screening tools, peer recovery support, and training resources.

Each subcommittee within the Council had an opportunity to share the progress being made by the group. The co-chairs of the Council concluded the meeting by sharing their vision for the Council and providing pertinent updates.

Meeting 2 – March 19, 2024

The meeting began with introductions, announcements, and the approval of the minutes from the January Council meeting. Members of the Council then received a Director's Report discussing updates from the BHA, which included updates from legislative session, interest in reforming the 1915(i), regulations out for public comment, and BHA staff updates. The Council then received a presentation from the Community Behavioral Health (CBH) Association of Maryland that discussed the results of CBH's measurement-based care implementation work group. The presentation discussed the logistics of the measurement-based care project and the lessons learned.

The co-chairs of the Council discussed the Council's bylaws and the next steps for their eventual revision. Members of the Council were given an opportunity to share feedback after this presentation. Each Council subcommittee then presented their updates since the previous meeting.

Meeting 3– May 21, 2024

The meeting began with introductions, announcements, and the approval of the minutes from the March Council meeting. Members of the Council received a Director's Report discussing updates from the BHA, which included BHA staffing updates and information on crisis regulations. The MDH Office of Governmental Affairs then provided an overview of the Department's efforts during the 2024 Legislative Session. The Department also provided a presentation for Council members about the new coordinating mandate which requires that the Council and the Commission meet jointly at least three times per year and coordinate on their annual reports. The presentation elaborated on the differences between the statutory charges of the two groups and discussed the new reporting requirements for the groups set forth by SB 212/HB 1048.

To help contextualize the need for behavioral health services in the State as well as the gaps in care, members of the Council also received a presentation about the FY2022 Behavioral Health Updated Needs Assessment and White Space Analysis, which included an analysis of both adult and youth behavioral health service utilization in the State. Members of the Council were given an opportunity to share questions and feedback after this presentation. Each Council subcommittee then presented their updates since the previous meeting.

Meeting of the Behavioral Health Care Treatment and Access Commission

Meeting 1 – May 29, 2024

Similar to the Council's May meeting, the Commission received a presentation about the new coordinating mandate which requires that the Council and the Commission meet jointly at least three times per year and coordinate on their annual reports. The Commission also received the same presentation as the Council about the FY2022 Behavioral Health Updated Needs Assessment and White Space Analysis.

Commission members also received information about MDH's overdose data, which provides geospatial analysis of overdose fatalities and Naloxone distribution in the State, and learned about the upcoming Self Service Dashboard which will allow self-serve access to overdose data visualization. They then received presentations on The Maryland Health Care Commission's Behavioral Health Workforce Study and the Maryland Consortium on Coordinated Community Supports which each provided overviews of the duties and functions of their respective organizations. At the conclusion of the meeting, there were opportunities for both members of the Commission and members of the public to make comments.

Joint Meetings of the Behavioral Health Advisory Council and the Behavioral Health Care Treatment and Access Commission

Joint Meeting 1 – July 16, 2024

To supplement the requirement of the Commission and Council to report on the continuation of the State's behavioral health care-out, Health Management Associates (HMA) gave a presentation on Effective Strategies for Behavioral Health Benefit Management. HMA posed discussion questions at the end of their presentation that would be distributed to Commission and Council members for feedback.

The Commission and Council then received two presentations:

- The first discussed findings from Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program and learned about efforts to improve the EPSDT mental health and SUD screenings.
- The second presentation outlined the Temporary Pause on Certain New Provider Enrollments from the Centers for Medicare and Medicaid Services. Commission and Council members were given an opportunity after this presentation to provide comments.

The meeting concluded with a discussion of alignment between the Council's subcommittees and the Commission's workgroups to enhance the efficiency of the groups. At the conclusion of the meeting, there was an opportunity for members of the public to make comments.

Joint Meeting 2 – September 17, 2024

At the start of this second joint meeting, staff provided an overview of the survey results from the July HMA presentation, which provided insight into the current state of the behavioral health management system in Maryland. Following the summary of the survey results, HMA provided a presentation regarding considerations for a behavioral health model in Maryland. HMA posed additional discussion questions at the end of their presentations that would be distributed to Commission and Council members following the meeting for feedback.

Each Workgroup and Subcommittee, some working jointly for the first time, had an opportunity to report on their group's progress. At the conclusion of the meeting, there was an opportunity for members of the public to make comments.

Joint Meeting 3 – November 19, 2024

At the final joint meeting staff provided an overview of the results of the second HMA survey, which was distributed to Commission and Council members to discuss the questions posed at the end of their presentation in September. The results provided a better understanding of the ways in which the quality of the State's current behavioral health care system can be improved. Commission and Council members then received presentations from the BHA on the Report on Strategic Implementation of State Resources for Opioid Response and the BHA Fiscal Year 2025-2027 State Plan.

The Workgroups and Subcommittees then provided overviews of their annual reports. The meeting concluded with an overview of the procedures for the annual joint Committee and Council report and a discussion of the timeline for the report. At the conclusion of the meeting, there was an opportunity for members of the public to make comments.

Part 6: Workgroup Reports

Each of the statutorily required workgroups met once in 2024 and submitted a final report to the full Commission. The four workgroup reports can be found in Appendix 4. Appendix 5 includes an overview of the Council's subcommittees. It is important to note that in the first few months of the Commission and Council meeting jointly, some of its workgroups and subcommittees began to align their efforts. Specifically, the Criminal Justice and Children's-focused workgroups and subcommittees, made progress in aligning their work.

Geriatric Behavioral Health. The Geriatric Behavioral Health Workgroup is Chaired by Ben Steffen, Executive Director of the Maryland Health Care Commission. In 2024, the Geriatric Workgroup convened twice to hear presentations by the Maryland Primary Care Program (MDPCP) and the Maryland Health Care Commission. These presentations covered behavioral health integration efforts within primary care offices, and the Certificate of Need process in Maryland, inpatient behavioral health capacity, and projected workforce shortages. The Workgroup held a discussion of potential solutions. The Maryland Department of Aging also presented an overview of Longevity Ready Maryland. The Office of Harm Reduction, Maryland Behavioral Health Administration, presented on the Regrounding our Response Framework, overdose and substance use trends among older adults, and harm reduction strategies.

The Geriatric Workgroup requires additional meetings during the next calendar year before the Workgroup can make new recommendations. The Workgroup maintains that the 2023 recommendations remain relevant: (1) Expand the Behavioral Health Workforce; (2) Improve Access to Treatment and Community Supports; (3) Addressing loneliness and need for Caregiver Support. In 2025, the Geriatric Workgroup intends to focus on substance use disorders and harm reduction efforts in Maryland and learn about unique considerations for an older population, including Medicare coverage disparities. The workgroup plans to incorporate Longevity Ready Maryland plans into its recommendations. The Workgroup will examine, with assistance of MHCC staff, Medicare beneficiaries' access to behavioral health services through traditional Medicare and through Medicare Advantage plans.

Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs. Alyssa Lord, Deputy Secretary for the Behavioral Health Administration, chairs the Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs Workgroup. This group began to meet jointly with the Council's Children, Youth Adults and Families Committee, co-chaired by Christina Greene, Maryland Coalition of Families for Children's Mental Health, and Kimberlee Watts, family member with lived experience, to further align their work moving into calendar year 2025.

The workgroup reviewed the preliminary overview of the "Roadmap for Change" presented by the Maryland Coalition of Families (MCF) and Manatt Health. The Roadmap detailed the existing landscape of Maryland's PBHS and the feedback received from focus groups. Workgroup members recommended several opportunities for Maryland, including improved collaboration between agencies and with youth and families, and increased investment in services and supports across the behavioral health continuum of care. The Workgroup has since received a second presentation from MCF and Manatt, which provided an overview of the first draft of the Roadmap. In addition to the presentation, the Workgroup identified topics for exploration in Calendar Year 2025 meetings that address the charge of the Workgroup.

Criminal Justice-Involved Behavioral Health. Dr. Aliya Jones, representative of an acute care hospital, and Judge Marina Sabett, representative of the Maryland Judiciary District Court, jointly chair the Criminal Justice-Involved Behavioral Health Workgroup. This reflects the joining of a workgroup and subcommittee from the Commission and Council, respectively. During its three meetings in 2024, the Criminal Justice-Involved Behavioral Health Workgroup received an overview of the competency and Not Criminally Responsible processes, learned more about the MDH psychiatric facilities and currents trends within the MDH Healthcare System, and received an update about the Assisted Outpatient Treatment program. The group proceeded to synthesize this information in order to determine areas of interest to inform formal recommendations for action in accordance with the charges of the Workgroup. In 2025, the Workgroup plans to learn more about how it can examine the needs of the criminal justice-involved population, including by investigating substance use disorder treatment and community services following discharge.

Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing. Marie Grant, Acting Maryland Insurance Commissioner, chairs the Behavioral Health Workforce Development, Infrastructure, Coordination, and Financing Workgroup. In 2024, the Workgroup established a core understanding of the current state of behavioral health financing in Maryland, in order to make future recommendations that are both reasonable and realistic. The Workgroup learned about both Medicaid and commercial structures for reimbursing behavioral health care, including a detailed examination of the Medicaid carve-out model and an understanding of State and Federal parity requirements.

The Workgroup's 2024 recommendations primarily focused on the MHCC's detailed needs assessment of the current behavioral health workforce, with a number of key areas identified for review in 2025. The Workgroup endorses the six recommendations in the MHCC report, which include: (1) Provide competitive compensation for behavioral health providers.; (2) Greater awareness of opportunities in behavioral health, starting in high school and through higher education; (3) Support paid education and training ("earn and learn" concept); (4) Streamline licensing processes such that they are more effective; (5) Invest in the quality of job opportunities; and (6) Expand impact of the current workforce. In addition to the MHCC recommendations, the workgroup identified a handful of additional recommendations related to the need for an adequate, culturally competent, and diverse workforce across the BH continuum

which are: (1) Including para-professionals within all workforce considerations (e.g., Peer Support Specialist, Peer Recovery Specialist (PRS) and Family Peer Support Specialist); (2) Team-based treatment models be centered in both workforce and reimbursement discussions; (3) Workforce considerations must include a focus on fostering safety among providers and service settings; and (4) Including direct information and perspectives from behavioral health care workers in Maryland in the Workgroup's work and reports.

Council Planning Committee. The Council's Planning Committee is co-chaired by Tammy Loewe, LCSW-C, Behavioral Health Division of St Mary's County Health Department and Tim Santoni, Administrator of Data Management. Systems Evaluation Center at the University of Maryland. The Planning Committee met monthly throughout 2024 in addition to several ad hoc meetings. One major focus of the Planning Committee has been the updating of the Council By-Laws. The committee prepared a draft of the revised By-Laws and plans to present them to the full Council soon. A second area of focus for the Planning Committee was reexamining the role of the Council in providing support and recommendations to BHA to improve the public behavioral health system. While the subcommittees have shared insight and provided some recommendations, the full Council has made very few formal recommendations. The Council currently receives a report on legislative activity and the Planning Committee has discussed ways the Council might stay aware of relevant legislation and, if appropriate, provide testimony on proposed legislation. The Planning Committee also discussed asking BHA for more information about and involvement with the State Opioid Response grants, since those grants are significantly larger than the combined Federal Block Grants. Lastly, the Planning Committee discussed where there may be opportunities for the Council to be informed of decisions made in response to the "crisis of the day", often establishing, either implicitly or explicitly, a new or revised policy.

Council Cultural and Linguistic Competency Committee (CLCC). The Council's Cultural and Linguistic Competency Committee (CLCC) is chaired by Sharon MacDougall, a family member with lived experience, and Usherla DeBerry, Director of the Governor's Office of the Deaf and Hard of Hearing. The CLCC assists the Council in its role of gathering and disseminating information about the role culture plays in the delivery of behavioral health services in the behavioral health system. In 2024, the CLCC discussed several topics related to the behavioral health needs and concerns for the deaf and hard of hearing community. Specifically, the CLCC discussed the need for workforce development to support social workers and other behavioral health professionals who are deaf or hard of hearing. This generated a recommendation that licensure exams for behavioral health professionals be adapted to better accommodate the deaf and hard of hearing to ensure greater representation in the behavioral health workforce. The CLCC also discussed legislation was passed this year (HB 1069) that requires the Office on the Deaf and Hard of Hearing (ODHH) to establish a workgroup "to study and make recommendations regarding services, programs, advocacy, and outreach and other efforts to improve the quality of life for individuals who are deaf, deafblind or hard of hearing." The Committee noted that behavioral health is an important topic that should be considered in any recommendations developed by that workgroup. Lastly, the Committee noted that the MD

Association of the Deaf (MDAD) now has a mental health committee and that the work of this new committee may be of interest to the CLCC.

Appendix 1 - Maryland Behavioral Health Advisory Council Members

	Name	Organization
	The Hon. Steven C. Johnson	The Maryland House of Delegates
	Marlana R. Hutchinson	The Office of the Deputy Secretary of Developmental Disabilities, Maryland Department of Health
	Alyssa Lord	The Office of the Deputy Secretary for Behavioral Health, Maryland Department of Health
	Ryan Moran	The Office of the Deputy Secretary for Healthcare Financing, Maryland Department of Health
	Helene Hornum	The Office of the Secretary, Maryland Department of Health
	Lynda Bonieskie	The Maryland Department of Public Safety and Correctional Services
	Jody Boone	The Maryland Division of Rehabilitation Services
	Kirsten Bosak	The Maryland Department of Disabilities
	Usherla DeBerry	The Governor's Office of Deaf and Hard of Hearing
	Mary Gable	The Maryland State Department of Education
	Katharine Gibson	The Maryland Department of Budget and Management
	Kim Hall	The Maryland Department of Juvenile Services
	Dayna Harris Mayo	The Maryland Department of Housing & Community Development
	Johanna Fabian-Marks	The Maryland Health Benefit Exchange
	Mary Drexler	The Maryland Center of Excellence on Problem Gambling
	James Rhoden	The Governor's Office of Crime Prevention, Youth, and Victim Services
	The Hon. Marina K. Sabett	The Maryland Judiciary District Court
	The Hon. Heather L. Price	The Maryland Judiciary Circuit Court

	Hannibal Kemerer	The Office of the Public Defender
	Susan M. Doyle	The Maryland Association of County Health Officers
	Kathryn Dilley, Chair	The Maryland County Behavioral Health Advisory Council
	Andrea McDonald Fingland	The Maryland County Behavioral Health Advisory Councils
	Bari Klein	The Maryland County Behavioral Health Advisory Council
	Tim Santoni	The Maryland County Behavioral Health Advisory Councils
	Tammy Loewe	The Maryland Association of Behavioral Health Authorities (MABHA)
	Carlos Hardy	The Maryland Recovery Organization Connecting Communities
	Christina Greene	The Maryland Coalition of Families for Children's Mental Health
	Andrea Brown	The Black Mental Health Alliance for Education and Consultation Inc.
	Shannon Hall	Community Behavioral Health Association of Maryland
	Kim Wireman	The Maryland Addiction Director's Council
	Leslie Seid Margolis	Disability Rights Maryland
	Vickie Walters	The Maryland Association for the Treatment of Opioid Dependence
	Keith Richardson	The National Council on Alcoholism and Drug Dependence of Maryland
	Linda Raines	Mental Health Association of Maryland, Inc.
	Jean JB Moore	The National Alliance on Mental Illness of Maryland
	Michelle Livshin	On Our Own of Maryland, Inc. Consumer (Adult)
	Joseline Castanos	Community Advocate
	Candace Harris	Community Advocate
	Sharon MacDougall	Family Member

	Kimberlee Watts	Family Member
	Laura Kimmel	Parent of a young child with a behavioral health disorder
	Johanna Dolan	Consumer
	Brendel Mitchell	Consumer (Youth/Young Adult)
	Joyce Harrison	Academic/Research Professional-Not State Employee
	Kathryn M. Hart	Academic/Research Professional-Not State Employee
	Dan Morhaim	Medical Professional
	Jerica Washington	Medical Professional

Appendix 2 - Commission Members

Commission Chair

- Laura Herrera Scott, Secretary of Health

Commission Members

- Senator Malcolm Augustine, Member from the Senate of Maryland
- Delegate Bonnie Cullison, Member from the Maryland House of Delegates
- Stephen Ligett-Creel, Designee for the Department of Human Services
- Alexa Herzog, Designee for the Department of Juvenile Services
- Deputy Secretary Alyssa Lord, Deputy Secretary for Behavioral Health
- Kathleen Birrane, Maryland Insurance Commissioner
- Megan Renfrew, Designee for the Executive Director of Health Services Cost Review Commission
- Ben Steffen, Executive Director of the Maryland Health Care Commission
- Mark Luckner, Executive Director of the Maryland Community Health Resources Commission
- Sheena Patel, Designee for the Executive Director of State-Designated Health Information Exchange
- James Rhoden, Designee for the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victims Services
- Secretary Carol Beatty, Secretary of the Maryland Department of Disabilities
- Renard Brooks, Designee for the Secretary of the Department of Public Safety and Correctional Services
- Emily Keller, Special Secretary of Opioid Response
- Appointed by the Governor:
    - Linda Raines, representative of the Mental Health Association of Maryland
    - Kathryn Spencer Farinholt, representative of the National Alliance on Mental Illness
    - Shannon Hall, representative of the Community Behavioral Health Association of Maryland
    - Johnathan Davis, representative of a provider of residential behavioral health services
    - Dr. Aliya Jones, representative of an acute care hospital
    - Stacey Garnett, representative of an inpatient psychiatric hospital
    - Dr. Paula Anne Smith- Benson, individual with experience as a consumer of behavioral health services
    - Debra Bennett, family member of an individual with experience as a consumer of behavioral health services
    - Mercia Cummings, representative of a provider of substance abuse treatment services
    - Dr. Arlene Tyler, representative of a school-based health center
    - Tamar Rodney, individual with expertise in Social Determinants of Health
    - Matthew Eisenberg, individual with expertise in health economics

- Oleg Tarkovsky, representative of a health insurance carrier
- Linda Dietsch, representative of a managed care organization
- Benjamin Charlton, representative from the Office of the Public Defender
- Rachel London, representative of the Developmental Disabilities Coalition
- Kevin Amado Sr. representative of the Maryland Chapter of the National Council on Alcoholism and Drug Dependence
- Dr. Stephanie Wolf, representative of the Maryland Psychological Association
- Leslie Seid Margolis, representative of Disability Rights Maryland
- Lawanda Williams, representative of a Federally Qualified Health Center
- Kathryn Dilley, representative of a local behavioral health authority
- Clara Baker, individual with an intellectual disability who uses self-directed behavioral health services
- Irene Dey, Esq., representative of the Maryland State's Attorneys' Association

Appendix 3 - *Joint Chairmen's Report* on Overdose Activities (see attached)

Appendix 4 - Workgroup Reports (see attached)

Appendix 5 - BHAC Sub-Committee Overview

The Maryland Behavioral Health Advisory Council's committee structure consists of standing committees and ad hoc committees to facilitate the Council's role of gathering and disseminating information.

1. Committee membership is not limited exclusively to Council members except the Executive and Nominating committees.
2. The Council may adopt procedures necessary to do business, including creating committees or task forces. Standing and ad hoc committees may be convened as determined by the Council Co-Chairs and agreed upon by the Executive Committee.
3. The committees will make recommendations to enhance aspects of the behavioral health system and ensure a coordinated, culturally and linguistically competent, quality system of care that is outcome-guided and integrates prevention, recovery, evidence-based practices, and cost-effective strategies in delivering behavioral health services state-wide.
4. Council members are requested to serve on at least one Committee.

Executive Committee

Charge of the Executive Committee

The Executive Committee shall meet as needed, and its responsibilities include but are not limited to:

1. Preparing, reviewing, or approving testimony or other public presentations, documents, or reports submitted on behalf of the Council when there is insufficient time for review and approval by the entire Council, mainly when timing is critical.
2. Developing and identifying directives and initiatives for standing and ad hoc committees.
3. Providing oversight, when necessary, to ensure that each Committee of the Council completes its assigned special projects.

Executive Committee Members:

1. Kathryn Dilley, BHAC Chair
2. Tim Santoni, BHAC Planning Committee Co-Chair
3. Tammy Loewe, BHAC Planning Committee Co-Chair
4. Sharon MacDougall, BHAC Cultural and Linguistic Committee Co-Chair
5. Usherla DeBerry, BHAC Cultural and Linguistic Committee Co-Chair
6. Christina Green, BHAC Children, Youth Adults and Families Committee Co-Chair
7. Kimberlee Watts, BHAC Children, Youth Adults and Families Committee Co-Chair
8. Kirsten Bosak, BHAC Prevention Committee Co-Chair
9. Judge Marina Sabett, BHAC Criminal Justice/Forensics Committee Co-Chair

Planning Committee

Charge of the Planning Committee

The Planning Committee's activities focus on meeting the Federal Block Grant requirements. Its responsibilities include:
1. Participating in a year-long planning process to develop, review, and finalize recommendations for the Maryland Behavioral Health Plan and the Federal Block Grant Application, which may inform special projects.
2. Identifying key focus areas or issues for monitoring and making recommendations to the Council.
3. Contributing to the development of the Annual Report, which summarizes the Council's activities, priorities, and recommendations and is submitted to the Governor annually.
4. Continuously providing input to identify work groups and targeted projects for the Lifespan Committee.
5. Offering guidance on the action plans of ad hoc committees or special study/workgroup committees to ensure alignment with the goals and priorities of the Behavioral Health Administration.

Committee Members:
Tim Santoni, BHAC Planning Committee Co-Chair
Tammy Loewe, BHAC Planning Committee Co-Chair

Cultural and Linguistic Committee

Charge of the Cultural and Linguistic Competence Committee
The Cultural and Linguistic Committee supports the Council in collecting and sharing information about the impact of culture on the delivery of behavioral health services within the behavioral health system.

The Committee produces recommendations and ideas to enhance cultural and linguistic competence and develop culturally responsive services that are vital for the behavioral health system, providers, and communities throughout the state. These recommendations and ideas address specific cultural groups and communities in Maryland, including considerations related to gender, gender identity, and disability. They shape and inform strategies integrated into state, federal, and local planning processes.

Committee Members:
Sharon MacDougall, BHAC Cultural and Linguistic Committee Co-Chair
Usherla DeBerry, BHAC Cultural and Linguistic Committee Co-Chair

Criminal Justice/Forensics Committee

Charge of the Criminal Justice/Forensics Committee
The Committee provides recommendations for the Administration on delivering behavioral health services for individuals involved in the criminal and juvenile justice systems who are court-ordered to the Maryland Department of Health for evaluation, commitment, or treatment concerning their competency to stand trial or criminal responsibility.

The target audience focus is those with mental health issues, substance-related disorders, or co-occurring disorders who are incarcerated or at risk of being incarcerated in jails, prisons, and detention facilities.

Additionally, the Committee aims to address the intersection of behavioral health and the criminal justice system, ensuring access to housing, mental health treatment, and substance use services. It also emphasizes the importance of legislative actions and programmatic reforms.

Committee Members:
Judge Marina Sabett, Criminal Justice/Forensics Committee Co-Chair
Vacant Criminal Justice/Forensics Committee Co-Chair

Children, Youth Adults and Families Committee

Charge of the Children, Youth Adults, and Families Committee
Focuses on addressing the mental health and substance use needs of these children, young adults, and families; the Committee's primary functions include:

- Policy development and advocacy
- Service coordination
- Family and youth involvement
- Cross-system collaboration
- Works with other relevant stakeholders, such as community organizations and health systems, to create comprehensive behavioral health networks.
- The Identification recommendations for developing strategies and initiatives, including evidence-based practices, are essential for a comprehensive system of care for behavioral health services and supports for children, young adults, and families.

Committee Members:
Christina Green, Children, Youth Adults and Families Committee Co-Chair
Kimberlee Watts, Children, Youth Adults and Families Committee Co-Chair

Recovery Services and Support Committee

Charge of the Recovery Services and Support Committee
The Committee identifies recommendations for developing strategies and initiatives, including evidence-based practices, which are essential for a comprehensive system of behavioral health services and supports for adults and older adults.

Committee Members:
Vacant, Children, Youth Adults, and Families Committee Co-Chair
Vacant, Children, Youth Adults, and Families Committee Co-Chair

Prevention Committee

Charge of the Prevention Committee

The Committee provides guidance and advocacy in Prevention across the lifespan. This may include areas such as Substance-related Prevention, suicide prevention, addictive behaviors such as gambling.

This Committee examines data and research, identifies risk factors and evidence-based resources, and makes recommendations or suggests strategies to the Behavioral Health Administration as appropriate and/or as elements for further study.

Committee Members:
Kirsten Bosak, Prevention Committee Co-Chair
Vacant Prevention Committee Co-Chair

Appendix 6 - History of Maryland's Medicaid Behavioral Health ASO Model