COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

Public Testimony
Medicaid Advisory Committee | May 23, 2024

Good afternoon. I am Shannon Hall, Executive Director of the Community Behavioral Health Association of Maryland, representing mental health and addiction treatment providers across the state. I am speaking today to comment on the Maryland Department of Health's plans to beef up Maryland's primary care program by increasing evaluation and management (E&M) code reimbursement rates as part of the AHEAD model.

While we support the focus on primary care, we were taken aback by MDH's change in policy regarding E&M code increases. In 2017, the General Assembly – in response to concerns about the financial viability of community behavioral health providers – passed the HOPE Act, which created the first-ever mandated rate increases for community behavioral health providers. They were carried over into the minimum wage act of 2019.

However, none of those increases applied to the E&M codes used by psychiatrists and psychiatric NPs in outpatient behavioral health clinics because the Department's policy was that E&M codes should apply to *all* prescribers. That was a blow to us because we have been struggling to attract and retain prescribers for our community clinics. However, we understood this to be MDH's policy.

Now we hear that PCPs will get an E&M code increases but prescribers in our outpatient behavioral health clinics will not. This is problematic on a number of levels:

1. A recent research study by RTI on the commercial insurance market stated that Maryland was one of the worse states in terms of reimbursement disparities between somatic clinicians and BH clinicians:
   - MD out-of-network use for BH is 4th worst in the nation.
   - Marylanders are nearly 9 times more likely to go OON for BH vs primary care.
   - MD in-network behavioral health clinicians are reimbursed 23% less than other clinicians performing similar services.

   We should not adopt practices in the Medicaid market that will emulate this kind of disparity between somatic and behavioral health. Unfortunately, the decision to raise primary care E&M rates – but not behavioral health E&M rates – will do just that. This seems a *de facto* violation of the federal parity act.

2. Specialists in the somatic world (such as cardiologists or orthopedists) can offset their Medicaid losses with the much higher reimbursement they receive from commercial insurance. But psychiatrists and psych NPs in our outpatient clinics are reimbursed by commercial carriers at the same or lower rates than Medicaid. There is no offset for them.

3. Everyone acknowledges the mental health crisis we are now in – and it is affecting kids and adults. This is an opportunity to align our policies and funding with the need that everyone agrees must be addressed.

In closing, we agree with the Department's focus on primary care as a way to avoid preventable ED and inpatient utilization. But the same is true in BH – our clinics are primary BH care – and should be prioritized and treated in the same fashion as somatic primary care.