mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

2024 SESSION SUMMARY

The 446th legislative session of the Maryland General Assembly ended on April 8. After working in 2023 to pass a landmark package of behavioral health reforms, the MHAMD public policy team and our coalition partners saw success again in 2024, coordinating effectively with the legislature and with leaders in Governor Wes Moore's administration to enact policies designed to improve access to quality mental health and substance use care for Marylanders of all ages.

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2024 Legislative Briefing and Reception

As it does each year, MHAMD hosted a Legislative Briefing and Reception in Annapolis early this session to highlight policy priorities and build momentum for coalition advocacy efforts. The event focused this year on younger Marylanders and featured the premiere of an MHAMD-produced short film featuring honest accounts from Maryland youth and caregivers about their experience navigating the state's behavioral health system and their hopes for the future.

We were pleased to be joined this year by Lt. Governor Aruna Miller who spoke at length in support of MHAMD's efforts. "Every child deserves equal opportunities to succeed regardless of the circumstances they are born into," Miller said. "We need to hear from those going through the lived experiences because those closest to the challenge are closest to the solution."

The briefing also included a moderated panel of leaders from Maryland's child-serving agencies, policy updates from Moore administration officials and members of the General Assembly, and an awards ceremony honoring four Maryland behavioral health champions. Links to these presentations and a photo gallery from the event are available on the MHAMD website.

Maryland Behavioral Health Coalition

The Behavioral Health Coalition advanced a core set of priorities in 2023, including new initiatives to improve community mental health and substance use care and expand Maryland's behavioral health workforce. While the group is heavily focused on ensuring the successful implementation of these policies, the Coalition nevertheless played a major role this session as the legislature considered proposals to strengthen enforcement of behavioral health parity laws, fully fund Maryland's 988 program, review the structure of the state's public behavioral health system, and expand Maryland's behavioral health workforce.

Behavioral Health Parity

Under federal and state parity laws, Marylanders are entitled to receive mental health and substance use benefits at the same level as other medical benefits. But many Marylanders still face barriers in accessing behavioral health care that are not imposed for physical health care. This led the General Assembly in 2020 to establish new reporting requirements for health insurance companies (carriers) to determine their compliance with these laws. In late 2023, the Maryland Insurance Administration (MIA) published a report[1] summarizing its findings from the first round of these carrier compliance reports. After determining that the reports submitted by carriers were "uniformly and significantly inadequate, impeding the ability to reach parity determinations," the MIA recommended a variety of new reporting requirements and enforcement options to "improv[e] the ability of regulators to reach substantive conclusions on parity compliance."

SB 684/HB 1074 (passed) enacts many of the recommendations from the MIA's report, strengthening parity compliance reporting requirements for carriers and enhancing the MIA's parity enforcement authority. Specifically, the bill:

- Removes the sunset on carrier reporting requirements, requiring carriers to continue submitting compliance reports every other year.
- Reduces the scope of carrier compliance reports to just those nonquantitative treatment limitations (NQTL)[2] identified by MIA as having the biggest impact on access to care, improving the efficiency and effectiveness of the agency's parity analyses.
- Requires carriers to document compliance for all NQTLs annually and submit their reports to the MIA upon request within 15 days. Plan members are also authorized to request NQTL reports and receive those reports within 30 days, regardless of whether the member has filed a grievance, appeal, or complaint.
- Requires carriers to conduct and document comparative analyses for legacy NQTLs that were implemented prior to passage of the federal Parity Act.
- Places the burden of persuasion on the carriers to demonstrate parity compliance and provides that a failure to submit a complete report shall be considered a parity violation.
- Authorizes MIA to penalize carriers financially for each day a carrier does not submit requested information, charge carriers for expenses incurred by the MIA for additional reviews required beyond the initial review, and, should the agency be unable to determine compliance due to an incomplete carrier report, order the carrier to modify or cease the conduct or practice.

[1] 2023 Interim Report on Nonquantitative Treatment Limitations and Data. Maryland Insurance Administration. December 1, 2023. https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data-MSAR-12745.pdf

[2] NQTLs are processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided in a health insurance plan, including things like prior authorization, concurrent review, network adequacy, and provider reimbursement.

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In 2022 the Maryland General Assembly established the 988 Trust Fund to reimburse for costs associated with designating and maintaining 988 as the universal telephone number for the state's suicide prevention and behavioral health crisis hotline and for developing and implementing a statewide continuum of behavioral health crisis response services. This Fund has been supported over the past few years with one-time federal and state general dollars. However, as demand for behavioral health crisis care has increased and public awareness about 988 has grown, Maryland's 988 call centers have seen steadily rising call volumes, making a dedicated and sustainable funding source essential.

SB 974/HB 933 (passed) establishes a new 25 cents per month 988 telecom fee modeled after the funding mechanism for 911. This nominal fee on cell phones and landlines will accrue directly to the 988 Trust Fund, generate more than $25 million each year, and allow the state's 988 call centers to hire more staff, invest in technology, and prepare for continued growth in the demand for 988 and behavioral health crisis services.

Maryland's Public Behavioral Health System

SB 212/HB 1048 (passed) adds to the charges of the recently established Commission on Behavioral Health Care Treatment and Access by requiring it to make recommendations regarding the continuation of the state's behavioral health carve-out and the financing structure and quality oversight necessary to integrate somatic and behavioral health services in the Maryland Medicaid program. These recommendations are due by July 1, 2025.

Developed over several decades, Maryland's public behavioral health system has a number of strengths and core components that are critically important to the more than 325,000 children and adults who depend on these services:

- In addition to the Medicaid population, it covers uninsured and underinsured individuals, Marylanders 65 and older, and those who are dually insured by Medicare and Medicaid
- It provides a single point of contact and uniform processes for community mental health and substance use treatment providers, reducing administrative burden so that more resources can be used for direct service delivery.
- It has a strong local management component to address different needs in different communities.

As we work to advance the shared goal of better integrating health care in furtherance of a public health system that treats the whole person – mind and body – MHAMD will work to ensure that any largescale system reform is done with an eye toward preventing a disruption in

care for individuals that rely on public behavioral health services and with a recognition for the elements that have made Maryland's system one of the best in the nation.

Behavioral Health Workforce

Federal data[3] released in early January revealed that Maryland has 64 federally designated mental health professional shortage areas (HPSAs)[4], including 14 entire counties. These shortage areas, in which less than 20% of residents are getting their mental health needs met, impact over 1.8 million Marylanders. Another indicator found that 16 of Maryland's 24 jurisdictions come in below the national average (350:1) in terms of population to mental health providers, with a number that are considerably lower.[5] Accordingly, MHAMD and our partners supported several bills this year aimed at expanding Maryland's network of behavioral health clinicians.

SB 409/HB 628 (passed) streamlines the Maryland licensure process for marriage and family therapists who already hold a license in good standing from another state. Reciprocal licensure is a key strategy in efforts to expand Maryland's behavioral health workforce. It increases access to care by adding depth to local labor pools.

Interstate licensure compacts are a similar strategy. These agreements allow professionals in one compact state to deliver care in other compact states. Maryland has already entered compacts for professional counselors and psychologists. Unfortunately, efforts this year to enter Maryland into compacts for social workers (SB 204/HB 34 (failed)) and advanced practice registered nurses (SB 359/HB 425 (failed)) were unsuccessful. The bills passed the House but died in the Senate among concerns about the ability to ensure high standards of care among out-of-state practitioners.

Children's Behavioral Health Coalition

Over the past decade, Maryland has seen a marked decline in the availability of services and supports for youth – especially for those with mental health and substance use needs – and the results have been devastating. Data from the Youth Risk Behavior Survey of 2021-22 shows that 29% of Maryland high school students and 23% of middle school students reported that their mental health was not good most of the time or always, and suicide attempt visits to hospital emergency departments among those under age 18 has increased 46%. MHAMD and partners on the Children's Behavioral Health Coalition (CBHC) supported a range of executive and legislative actions this session aimed at addressing this crisis.

[3] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[4] A HPSA is a geographic area, population group, or health care facility that has been designated by the US Health Resources and Services Administration (HRSA) as having a shortage of health professionals in one of three categories – primary care, dental health, and mental health
[5] https://www.countyhealthrankings.org/explore-health-rankings/maryland?year=2022&measure=Mental+Health+Providers&tab=1

Governor's Office for Children and the Children's Cabinet

Governor Moore announced at MHAMD's 2023 Legislative Briefing and Reception his intention to establish a Governor's Office for Children (GOC) dedicated to building a comprehensive network of supports, programs, and services for children and their families to promote social and emotional wellbeing, expand access to health services, reduce childhood poverty, and more. Early this session, that promise became a reality. Governor Moore established GOC via an executive order that also reestablished the Children's Cabinet and directed it to develop an interagency strategy to increase access to services and programs that support children and families, including mental health and substance use care. This coordinated effort to support younger Marylanders has been a key priority for CBHC, and, as indicated above, it was the focus of MHAMD's 2024 Legislative Briefing and Reception.

Access to Care

The General Assembly took a variety of steps this session designed to improve access to care and resources for youth with behavioral health needs and their families.

HB 522 (passed) requires the Maryland Department of Health to consult with a range of stakeholders to develop guidelines for the expansion of telehealth in schools that must be adopted by local school systems before the start of the 2025-2026 school year. The guidelines must cover a variety of operational, legal, and financial issues, including equity and prioritization of access, protocols for missed instruction, health insurance considerations, the feasibility of designating building space for telehealth appointments, and the rights, roles and responsibilities of students, parents, school systems, and health care providers.

It can sometimes be difficult for a family of a child with a disability to reach consensus with their child's school on what services and supports are needed to adequately access the "free, appropriate, public education" to which their child is entitled. In some instances, if an agreement cannot be reached, the matter will be determined at a mediation or due process hearing. However, while the schools are regularly represented at these proceedings by legal counsel, families are often unfamiliar with the nuances of special education law and unable to afford private counsel. SB 797/HB 903 (passed) establishes a program to provide eligible students and their families with legal, advocacy, and consultant services that can assist them in these disputes.

Barriers in accessing care are even greater for children and families with limited English proficiency, and behavioral health providers often lack the capacity and funding to offer translation and interpretation services. SB 991 (passed) aims to address these challenges by establishing a pilot program to reimburse mental health and substance use providers for language assistance services.

Juvenile Law Reform

In recognition of the high prevalence of mental health and substance use concerns among justice-involved youth, CBHC supported efforts in 2022 to reform Maryland's juvenile justice system and divert youth – particularly those with behavioral health needs – away from justice involvement. This session, in response to a perception of increasing juvenile crime, driven primarily by local state's attorneys and several local media outlets, legislators introduced HB 814 (passed), which sought to roll back many of the reforms enacted in 2022. MHAMD and partners voiced strong opposition to many of the proposals outlined in the bill and urged the General Assembly to maintain and enhance behavioral health supports as appropriate for justice-involved youth. As a result, the final bill provides more supportive services for certain justice-involved youth aged 10-12 and requires the Department of Juvenile Services (DJS) to report broadly on current service availability and unmet need for youth under DJS supervision, including access to behavioral health services.

Mental Health and Aging Coalition

The number of Marylanders over 60 years old is expected to reach 1.7 million by 2030 – an increase of 40% in just 15 years. By 2040 this population will comprise nearly 27% of all the state's residents.[6] This is Maryland's fastest growing population, and one with a unique set of mental health and substance use needs. Unfortunately, appropriate community care and behavioral health supports are inconsistent across the state. Accordingly, MHAMD and partners supported several executive and legislative initiatives this session to ensure and better coordinate quality behavioral health care for aging Marylanders.

Longevity Ready Maryland Initiative

In early January, Governor Moore signed an executive order establishing the Longevity Ready Maryland Initiative. The order directs the Department of Aging to develop a plan to coordinate efforts across state agencies and other stakeholders to proactively address the range of needs arising from a growing older adult population. Among its charges, the plan must include recommendations to better support the behavioral health of older Marylanders. MHAMD and the Mental Health and Aging Coalition have long advocated for this type of coordinated interagency approach to better serving older Marylanders, and we look forward to working with the Department of Aging to advance these efforts.

[6] State Plan on Aging 2022-2025. Maryland Department of Aging.
https://aging.maryland.gov/SiteAssets/Pages/StatePlanonAging/MD%20State%20Plan%202022-2025.pdf

Long Term Care Resident Rights

Assisted living programs are residential facilities that provide housing and supportive services, personalized assistance, health-related services (including behavioral health care), or a combination of such services to assist individuals with activities of daily living. In an effort to ensure these facilities, which vary greatly in size and competency, are meeting the needs of their residents, MHAMD supported HB 723 (passed). The bill establishes a set of rights for residents of assisted living facilities – including, among others, the rights to be free from mental and physical abuse, neglect, involuntary seclusion, and chemical restraints – and authorizes the Office of the Attorney General to enforce those rights via injunctive relief.

Assisted Outpatient Treatment

The debate in Maryland over the advisability of establishing an Assisted Outpatient Treatment (AOT) program – a legal framework by which individuals with serious mental illness may be compelled by a court to adhere to a regimen of outpatient behavioral health treatment – has continued for decades with passionate advocates on both sides. This year an AOT bill was introduced at the request of the Maryland Department of Health (MDH) and included among Governor Moore's list of 2024 legislative priorities. While MHAMD has been historically opposed to an expansion of court-ordered treatment, the public policy team worked in good faith with MDH, the governor's office and legislative leadership to craft a bill that is limited in scope, recovery-oriented, outcomes-focused, transparent, and protective of individual legal and civil rights. All concerns raised by MHAMD were considered and addressed and nearly every amendment we offered was adopted. Pursuant to SB 453/HB 576 (passed):

- All jurisdictions must have an AOT program by July 1, 2026. A county may establish their own program or opt not to, in which case MDH must establish a program in that county.
- AOT applies only to individuals with serious and persistent mental illness, which is defined as "a mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to meet the ordinary demands of life, and that may lead to an inability to maintain independent functioning in the community without intensive treatment and support." Serious and persistent mental illness is just one of several conditions that must be met before an individual may be subject to AOT. In addition, a court must find by clear and convincing evidence that:
    - The individual is at least 18 years old;
    - The individual has demonstrated a lack of adherence with treatment for the serious and persistent mental illness that has, within the prior 36 months, either:

        - twice been a significant factor in necessitating inpatient admission to a psychiatric hospital for at least 48 hours or receipt of psychiatric services in a correctional facility, or
        - once resulted in an act of serious violent behavior toward self or others, or patterns or threats of, or attempts at, serious physical harm to self or others;
    - In view of the individual's treatment history and current behavior, the individual is in need of AOT in order to prevent a relapse or deterioration that would create a substantial risk of serious harm to self or others;
    - The individual is unlikely to adhere to outpatient treatment on a voluntary basis, as demonstrated by a history of treatment nonadherence over the prior 36 months that is not due to financial, transportation, or language issues; and
    - In consideration of all these factors, AOT is the least restrictive alternative appropriate to maintain the health and safety of the individual.
- AOT treatment plans must be developed by a multi-disciplinary care coordination team in consultation with the individual and their representative, be recovery-oriented and consistent with evidence-based and evolving best practices in the treatment of serious and persistent mental illness, and include, at a minimum, services of a treating psychiatrist, case management, services of a certified peer recovery specialist and, if clinically appropriate, assertive community treatment. Care coordination teams must assist in connecting the individual to services that will help them successfully adhere to a treatment plan, including transportation, housing, accessibility services, and any other services necessary to address the individual's health-related social needs.
- Individuals subject to an AOT petition may voluntarily agree to the treatment plan, in which case the petition is dismissed.
- All rights normally afforded to an individual in a civil or criminal matter shall apply and an AOT order may not be used as the basis for involuntary commitment, may not be used against an individual in any subsequent legal matter that carries negative collateral consequences, and may not infringe on any right related to licensing, permitting, certification, privilege, or benefit.
- MDH must report each year on a range of program statistics, demographics, and outcomes, including results from the use of a clinically validated symptom tool to assess responsiveness of individuals to treatment.
- The AOT statute sunsets and requires reauthorization by the legislature after five years.

Fiscal Year 2025 Budget

The legislature gave approval to a $63 billion state budget during the last week of session. The budget funds Maryland's public behavioral health system – which is currently serving over 325,000 children and adults with mental health and substance use disorders – at $3.2 billion.

This is a decrease of $130.7 million, or 3.9%, from the FY24 allocation, due primarily to enrollment projections and various fund transfers.

The total number of individuals served by the public behavioral health system has been increasing since FY21, indicating an improvement in overall access to care. However, this growth has been driven mainly by an increase in the provision of mental health services. The number of individuals receiving substance use services decreased by nearly 18,000 from FY20 to FY21, reflecting challenges in accessing care during the first year of the COVID-19 pandemic, and that number has not rebounded to pre-FY20 levels. Compared to FY19, 9.4% fewer individuals accessed substance use care in FY23. These trends suggest that accessing care has become an even bigger barrier in the wake of the pandemic.

Reimbursements to mental health and substance use providers increase by $107 million in FY25 and account for approximately 87% of the public behavioral health budget. This includes a 3% rate increase across public behavioral health providers, plus an annualization of the 8% increase provided in January to coincide with an increase in the state's minimum wage.

More information about the FY25 public behavioral health system budget, including detailed spending breakdowns, is available in the Department of Legislative Services' Behavioral Health Administration budget analysis.

Reporting Requirements

In addition to the funding allocations referenced above, the FY 2025 budget also includes the following notable reporting requirements:

- Maryland Department of Health report on the range and effectiveness of the state's **overdose response efforts** *(to be included in the annual report of the Commission on Behavioral Health Care Treatment and Access)*
- Maryland Department of Health **staffing report** documenting the impact of recent salary adjustments and recruitment strategies *(due 8/15/2024)*
- Behavioral Health Administration reports on **provider overpayment recoupment and forgiveness efforts** stemming from the failed 2020 launch of Optum Maryland and **transition planning** for the launch of a new Administrative Services Organization on January 1, 2025 *(due 8/1/2024 and 12/1/2024)*
- Behavioral Health Administration report on efforts to fill **long-term vacancies** at the agency *(due 7/1/2024)*
- Maryland Medicaid report on efforts to expand **Medicaid reimbursement of school-based behavioral health services** *(due 1/15/2025)*
- Maryland Department of Aging update on the interagency **Longevity Ready Maryland** initiative *(due 12/15/2024)*

- Community Health Resources Commission report on **school behavioral health grants** administered via the Consortium on Coordinated Community Supports *(due 11/1/2024)*
- Department of Human Services report on **hospital stays by youth in out-of-home placements** *(due 12/1/2024)*

Other Important Behavioral Health Bills

Utilization Review

Too often private health plans rely on medical necessity criteria that are not consistent with evidence-based care for behavioral health conditions. According to a recent national patient-experience survey conducted by NORC, nearly 70% of Marylanders reported problems with their health insurance plan denying coverage for mental health or substance use care due to determinations that care was not medically necessary, coverage limits or care exclusions.

SB 791/HB 932 (passed) reforms Maryland utilization review[7] standards to limit such denials of needed care. It requires that insurance companies use utilization review criteria developed by a relevant non-profit health care provider professional society or be consistent with standards generally recognized by health care providers practicing in the relevant specialty. It also ensures that expedited reviews are based on the determination of the health care provider and not the insurance company, sets a timeframe for authorizing additional visits/days for an existing course of treatment, requires that denials explain why the request was not medically necessary and did not meet utilization review criteria, and provides that a request for care is deemed approved if the insurance company fails to make a determination within a required timeframe.

Behavioral Health Training and Awareness

Pressure to perform and physical injuries contribute to a high prevalence of stress, anxiety, depression and other behavioral health challenges among athletes, with one study finding that "student-athletes report higher levels of negative emotional states than non-student athlete adolescents."[8] Studies have also shown, however, that coaches can have a profound impact on promoting and supporting the mental health and wellbeing of student athletes. SB 165/HB 204 (passed) seeks to better leverage these relationships and opportunities by requiring that Maryland public schools and universities train coaches to recognize indicators of behavioral health challenges among students.

[7] "Utilization review" is a process by which a health insurance company, in advance of a health care service being rendered, reviews a health care provider's request for care to determine whether the service is medically necessary.
[8] Neal TL, Diamond AB, Goldman S, et al. Interassociation recommendations for developing a plan to recognize and refer student-athletes with psychological concerns at the secondary school level: a consensus statement. *J Athl Train*. 2015;50(3):231-249.

Veterans

According to the Department of Veterans Affairs, Maryland is home to approximately 350,000 veterans, 30,000 active-duty service members and 18,000 reservists/national guard members. Statistics related to the prevalence of mental illness and substance use among this population is troubling. Suicide is the second-leading cause of death among veterans under age 45,[9] and a total of 6,392 veterans, an average of 17.5 each day, lost their lives to suicide in 2021, including 89 Marylanders.[10] Given this prevalence, MHAMD supported several efforts this year designed to expand support for Maryland veterans living with behavioral health concerns. SB 412/HB 408 (passed) requires that each local mental health advisory committee include a member serving in the military or with experience with mental health care for veterans, and SB 615 (passed) establishes July 11 as Maryland Veterans Suicide Awareness Day.

Extreme Risk Protective Orders

In an effort to prevent gun violence and gun-related suicide, the General Assembly in 2018 authorized interested persons to petition a court for an extreme risk protective order (ERPO) to prohibit the possession of a firearm by a person who poses a danger of causing injury to self or others. However, unlike most other ERPO states, Maryland does not explicitly allow researchers to access ERPO petitions and court records. Without this important data, researchers are unable to effectively evaluate and make recommendations related to the effectiveness and equitable enforcement of the law. SB 905 (passed) addresses this concern by authorizing researchers affiliated with institutions of higher education who are conducting academic or policy research to review ERPO court records.

Psychedelic Assisted Therapy

Psychedelic-assisted therapies hold promise for treating some of the most intractable behavioral health conditions, including post-traumatic stress disorder, depression, and substance use disorder. At the same time, the complexity of issues surrounding the equitable adoption of these treatments – in particular, how to ensure successful adoption within the behavioral health field – is significant. Professional practice guidelines, training standards, and unified reimbursement strategies that will enable providers to receive equitable reimbursement from payers for delivering psychedelic-assisted therapy are all major policy areas that must be considered and defined. SB 1009/HB 548 (passed) establishes the Task Force on Responsible Use of Natural Psychedelic Substances to consider these and other issues and to determine how best to advance the use of psychedelic substances in a responsible, safe, equitable and data driven manner.

[9] https://www.mentalhealth.va.gov/suicide_prevention/data.asp
[10] https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-State-Data-Sheet-Maryland-508.pdf