Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 39 (Senator Lam)
Finance Health

Behavioral Health Rate Methodology Modernization - Workgroup Establishment and Study

This bill alters the behavioral health rate-setting study required under Chapters 571 and 572 of 2017, by requiring the Maryland Department of Health (MDH) to conduct the study by June 30, 2028, as specified. The bill also establishes the Workgroup on Behavioral Health Rate Methodology Modernization in the Maryland Health Care Commission (MHCC) to develop transparent, cost-based reimbursement methodologies for certified community behavioral health clinics (CCBHCs), outpatient mental health centers, and independent outpatient providers. A member of the workgroup may not receive compensation but is entitled to reimbursement for expenses. The bill also outlines reporting requirements for the workgroup. The bill does not (1) require an immediate rate increase; (2) mandate an appropriation; or (3) create a fiscal obligation in the absence of subsequent legislative or budgetary action. **The bill takes effect July 1, 2026, and the workgroup terminates June 30, 2028.**

Fiscal Summary

State Effect: MDH general fund expenditures increase by $181,700 in FY 2027 and $158,500 in FY 2028, and MHCC special fund expenditures increase by $210,300 in FY 2027 and $197,600 in FY 2028 for contractual staff and services to support the rate study and workgroup, respectively; additional costs may be incurred in the out-years, as discussed below. Revenues are not affected.

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
Revenues	$0	$0	$0	$0	$0
GF Expenditure	181,700	158,500	0	0	0
SF Expenditure	210,300	197,600	-	-	-
Net Effect	($392,000)	($356,100)	($-)	($-)	($-)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary/Current Law:

Workgroup on Behavioral Health Rate Methodology Modernization

The bill establishes the workgroup, which consists of members of the General Assembly, representatives from MDH, and individuals working in behavioral health care, among others. The Presiding Officers must jointly designate one legislative member and one provider member to serve as co-chairs.

MHCC, in consultation with MDH, the Department of Legislative Services (DLS), and the Community Behavioral Health Association of Maryland, must provide staff for the workgroup.

The workgroup must:

- use the federally required CCBHC cost study as the baseline dataset for evaluating outpatient mental health service costs in the State;
- review and analyze cost drivers for outpatient behavioral health, including (1) staffing mix and workforce models; (2) medical director and clinical supervision requirements; (3) contractor versus salaried structures; (4) geographic and volume variation; (5) compliance with State and federal regulatory requirements; (6) differentiation of costs between nonprofit and for-profit organizations; (7) ratio of services delivered by telehealth; and (8) size and volume of group-based services;
- approve methodologies for analyzing outpatient costs and MDH's completion of the required rate study that include (1) cost reporting structures; (2) sampling methodologies that exclude all programs founded after 2020; (3) allocation of overhead and administrative costs; (4) differentiation of the treatment of Medicaid vs. non-Medicaid provider revenues; and (5) modeling approaches used to estimate sustainable reimbursement rates;
- evaluate reimbursement methodologies used in other states and federal demonstration programs;
- develop at least one cost-based, rate-setting methodology applicable to CCBHCs, outpatient mental health centers, and independent outpatient providers that includes (1) re-evaluating and rebasing reimbursement rates under the CCBHC payment

model in demonstration year two and every three years thereafter; (2) assumptions, cost-model components, and inflationary adjustments; and (3) integration of data and analyses produced under the required rate study, to the extent data and analyses are available;

- build on all previously completed and ongoing cost-reporting and analytical work related to setting community provider rates for community-based behavioral health services in developing the aforementioned methodologies, including (to the extent available) the required rate study, the CCBHC cost and rate study required by the 2025 *Joint Chairmen's Report*, and cost reporting tools and submission review processes discussed below;
- ensure all recommended methodologies comply with both federal Medicaid financing rules and the Medicaid Upper Payment Limit and provide recommendations on strategies to implement the recommended methodologies while remaining compliant with federal requirements;
- identify any regulatory or statutory barriers to statewide implementation of cost-based, rate-setting methodologies; and
- propose options for phased statewide implementation of cost-based, rate-setting methodologies when fiscal conditions allow.

By June 1, 2027, the workgroup must submit an interim report to the Governor and the General Assembly. By December 1, 2027, the workgroup must submit a final report to the Governor and the General Assembly that includes (1) recommended rate-setting methodologies; (2) assumption and cost-model components; (3) options for phased implementation; (4) estimated fiscal considerations; and (5) any recommended statutory or regulatory changes.

Rate Study

Chapters 571 and 572 of 2017 require the Behavioral Health Administration (BHA) and the Medical Care Programs Administration (MCPA) to jointly (1) conduct an independent, cost-driven, rate-setting study to set community provider rates for community-based behavioral health services; (2) develop and implement a payment system incorporating the findings of the study, including projected costs of implementation and recommendations to address potential funding shortfalls; and (3) consult with stakeholders in conducting the rate study and developing the payment system. BHA was required to complete the rate study by September 30, 2019, and adopt regulations to implement the payment system as developed.

While the study has not yet occurred, the Behavioral Health System of Care Optimization and Integration Workgroup had discussions in 2019 and 2020 about requirements for the study, including stakeholder feedback. Based on the feedback, MDH decided to engage in

a two-phase process for the study. The first phase involves designing a cost report template for providers to use, while the second phase involves analyzing the data and conducting the study.

The bill alters the required rate study by requiring MDH, by June 30, 2028, to (1) conduct the required independent rate-setting study; (2) review and implement the recommendations of the Workgroup on Behavioral Health Rate Methodology Modernization; and (3) administer cost-reporting tools and oversee cost-report submissions required to support the rate study. MHCC must assist MDH with the facilitation of the rate-setting study, including by (1) consulting with stakeholders, including community providers and individuals receiving services and (2) providing analytical support and technical assistance.

Under the bill, BHA and MCPA must still jointly (1) develop and implement a payment system incorporating the findings of the rate-setting study and (2) consult with stakeholders, including community providers and individuals receiving services, in developing the payment system.

The bill requires the Secretary of Health (or the Secretary's designee) to designate a representative of BHA to serve as a technical liaison between MDH and MHCC. The technical liaison must (1) provide technical input for the completion of the rate-setting study regarding Medicaid policy, behavioral health reimbursement structures, and existing data sources; (2) ensure continuity between MDH's work regarding the completion of the study and MHCC's facilitation of the workgroup; and (3) coordinate MHCC's access to existing analytical work or study preparation that has been completed by MDH. The liaison must be a member of the workgroup.

The bill replaces obsolete reporting requirements for MDH with new reporting requirements for MHCC, as follows:

- By January 1, 2028, MHCC must submit an interim report to the Governor and General Assembly on (1) the delivery system through which community-based behavioral health services should be provided; (2) the status of the implementation of workgroup recommendations; and (3) any preliminary recommendations regarding the payment system; and
- By December 1, 2028, and annually thereafter, MHCC must submit a report to the Governor and the General Assembly on the impact of the rate adjustments and the payment system, including the impact on (1) the wages and salaries paid and the benefits provided to direct care staff and licensed clinicians employed by community providers; (2) the tenure and turnover of direct care staff and licensed clinicians employed by community providers; and (3) the ability of community providers to recruit qualified direct care staff and licensed clinicians.

Under current law, MDH may require a community provider to submit information necessary for the completion of the required report. The bill specifies that MHCC may require the submission of information.

Certified Community Behavioral Health Clinics

Chapter 275 of 2023 requires MDH to apply for grant funds related to CCBHCs from the Substance Abuse and Mental Health Services Administration (SAMHSA) for fiscal 2025 and 2026.

SAMHSA awards demonstration funding to states that have completed the planning grant and are prepared to implement the CCBHC model. Under the demonstration, Medicaid-eligible services provided at a CCBHC receive an enhanced federal match, and clinics are paid through a prospective payment system (PPS), which provides clinics with an average rate based on the estimated daily or monthly cost of operating the facility, regardless of the volume or type of service provided. This differs from a fee-for-service model, wherein Medicaid pays providers for each service given to a patient.

The federal CCBHC model is designed to ensure access to high-quality and comprehensive behavioral health care. CCBHCs are required to serve anyone seeking wraparound behavioral health care services, including care for mental health or substance use, regardless of their ability to pay, place of residence, or age.

Participating clinics must be certified by the State and meet specific State and federal criteria related to staffing adequacy, service accessibility, care coordination, quality and outcomes reporting, and organizational governance. CCBHCs must also provide nine core services either directly or through designated collaborating organizations: (1) crisis services 24 hours a day, seven days a week; (2) treatment planning; (3) screening, assessment, diagnosis, and risk assessment; (4) outpatient mental health and substance use services; (5) targeted case management; (6) outpatient primary care screening and monitoring; (7) community-based mental health care for veterans; (8) peer, family support, and counselor services; and (9) psychiatric rehabilitation services. CCBHCs also provide care coordination and may offer additional services depending on the needs of the service area.

There are currently five clinics in Maryland that operate under the CCBHC model; however, because Maryland is not currently participating in the demonstration program, these clinics are not able to use PPS, nor qualify for enhanced match. All five offer the required services and have received grant funding from SAMHSA to bridge the costs of providing CCBHC services.

Outpatient Mental Health Centers

Under Maryland regulations (COMAR 10.63.03.05), to be licensed, an outpatient mental health center must (1) provide regularly scheduled outpatient mental health treatment services in a community-based setting; (2) provide individual, group, and family therapy and medication management; (3) employ a medical director who is a psychiatrist, has overall responsibility for clinical services, and is on-site for at least 20 hours per week; and (4) employ multidisciplinary clinical treatment staff who is authorized to provide services. Chapters 274 and 275 and Chapters 481 and 482 of 2019 required updates to regulations to allow, respectively, (1) a medical director to be considered on-site through telehealth and (2) a psychiatric nurse practitioner to serve as medical director of an outpatient facility.

State Expenditures: MDH expenditures (general and special funds) increase by a total of $391,974 in fiscal 2027, which accounts for the bill's July 1, 2026 effective date. MHCC requires one additional staff (using a vacant position) and a contractual vendor to conduct analysis and draft reports for the workgroup, and BHA requires two additional staff to conduct the rate study. This estimate includes salaries, fringe benefits, one-time start-up costs, a contractual vendor, and ongoing operating expenses.

Contractual Positions	2.0
Salaries and Fringe Benefits	$262,469
Contractual Services	100,000
Other Operating Expenses	29,505
Total FY 2027 Total State Expenditures	**$391,974**

These positions are all assumed to be contractual and terminate at the end of fiscal 2028, along with the termination of the workgroup and the deadline for the rate study. Further details of each set of costs are outlined below.

Although the rate study was initially required by Chapters 571 and 572 of 2017, and DLS estimated that MDH would require contractual services and one full-time policy analyst to coordinate data collection, because the initial rate study has not been conducted, these are assumed to be all new costs.

Maryland Health Care Commission – Workgroup Staff and Annual Reporting

MHCC advises that it requires additional staff to lead the data analysis, develop options and recommendations, and draft reports for the workgroup. MHCC can likely use an existing, vacant contractual position; however, funding is required for the position and related costs. Thus, MHCC special fund expenditures increase by $210,275 in fiscal 2027, which accounts for the bill's July 1, 2026 effective date. This estimate reflects the cost of hiring one contractual methodologist (using MHCC's vacant position) to lead data analysis

efforts, write reports, and complete any other tasks related to the workgroup. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses, as well as $100,000 in annual contractual services for cost-based reimbursement analytic research and actuarial and fiscal analysis.

Salary and Fringe Benefits	$100,440
Contractual Services	100,000
Other Operating Expenses	9,835
Total FY 2027 MHCC Special Fund Expenditures	**$210,275**

Future year expenditures reflect a full salary with annual increases and employee turnover as well as annual increases in ongoing operating expenses. Costs are assumed to terminate at the end of fiscal 2028 along with termination of the workgroup; however, as MHCC must continue to report annually, MHCC advises it may incur additional costs. If so, rather than terminate, the contractual position may be converted to a regular position beginning in fiscal 2029.

This estimate does not include any health insurance costs that could be incurred for specified contractual employees under the State's implementation of the federal Patient Protection and Affordable Care Act (ACA).

Behavioral Health Administration and Rate Study Staff

BHA advises that it requires two additional staff to conduct the rate study. Thus, MDH general fund expenditures increase by $181,699 in fiscal 2027, which accounts for the bill's July 1, 2026 effective date. This estimate reflects the cost of hiring one contractual data analyst and one contractual health policy analyst to conduct the required rate study, review and implement workgroup recommendations, and administer and oversee cost reports. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Contractual Positions	2.0
Salaries and Fringe Benefits	$162,029
Operating Expenses	19,670
Total FY 2027 BHA General Fund Expenditures	**$181,699**

Future year expenditures reflect full salaries with annual increases and employee turnover as well as annual increases in ongoing operating expenses. Costs terminate at the end of fiscal 2028 upon the deadline to complete the rate study.

This estimate does not include any health insurance costs that could be incurred for specified contractual employees under the State's implementation of the federal Patient Protection and the ACA.

Additional Comments: MDH applied for and was awarded nearly $1.0 million in CCBHC planning grant funding in fiscal 2025 to determine how to implement the CCBHC program in the State. The current planning grant received a no-cost extension from SAMHSA and will expire in December 2026. MDH has indicated that it plans to apply for the four-year CCBHC demonstration grant in April 2026, but the Budget Reconciliation and Financing Act of 2026 includes a provision that would authorize, rather than require, MDH to apply for the grant and move the application date from fiscal 2026 to fiscal 2029.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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