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July 7, 2020

Aliya Jones, M.D.
Deputy Secretary for Behavioral Health
Maryland Department of Health

Dear Dr. Jones:

This letter reflects feedback from the Community Behavioral Health Association of Maryland (CBH) on the state's new medical necessity criteria for psychiatric rehabilitation programs serving children (PRP-M).

As you know, CBH represents 70 organizations, encompassing virtually every program type in the public mental health system. Collectively, our members report serving about 180,000 individuals annually, or roughly 80% of the individuals receiving publicly funded mental health services in FY2019.

CBH and its members have serious concerns regarding the impacts of BHA's amendments to PRP-M medical necessity criteria on provider organizations and the children they serve.

Lack of Notice Will Result in Massive Discharges with No Transition Planning or Continuity of Care

Optum distributed the new medical necessity criteria on Friday, June 26, after 4:45 PM, with implementation beginning on Wednesday, July 1. This left only two business days for providers to review and train staff on the new criteria.

At this point, our members are reporting that few children served in their PRP programs meet the new medical necessity criteria. As a result, our members are facing massive discharges from PRP with virtually no notice to children and families, no discharge or transition planning, and scant alternative treatment resources available. Children will lose access to PRP at a time when access to other supportive resources has been suspended as a result of COVID, and when many children and families are struggling with COVID-related impacts.

For these reasons, *we ask the state to immediately delay implementation of the new medical necessity criteria for children until September 1 in order to allow adequate time for transition planning and notice to families. This step must be taken immediately to prevent harm and disrupted care.*



Proposed Change Will Increase Unnecessary Hospital Utilization

Compared to other states, Maryland children use higher levels of care at dramatically higher rates. Nationally, less than 1% of children using publicly funded services are admitted to state psychiatric hospitals, inpatient hospitals, or residential treatment centers. In Maryland, an astonishing 13% of children in the public behavioral health system are admitted to such settings annually.¹

At the same time, Maryland's efforts to implement a wrap-around level of care for children at risk of hospitalization is plagued by low utilization over multiple years, operating 85% below its planned capacity. Maryland developed 1915(i) to prevent children with intensive behavioral health needs from hospitalization, but utilization continues to remain extremely low.²] The state has taken no policy actions to address known barriers and under-utilization in the program. Many CBH members delivering this level of care have dropped out of the program or are considering doing so.

Against this dismal backdrop, Maryland now proposes to radically reduce access to community-based psychiatric rehabilitation program for children. This would leave children with only outpatient treatment as an accessible service in the public behavioral health system. Unfortunately, 18 counties are classified in whole or in part as mental health shortage areas. This means that there simply aren't enough licensed professionals to meet the population's need for this service in the vast majority of Maryland.

Without any alternatives, the change in medical necessity criteria will effectively reduce utilization of psychiatric rehabilitation programs by children. With no other accessible service to meet their needs, the new medical necessity criteria seem destined to only increase Maryland's already over-reliance on inpatient utilization for children.

CBH Recommendations Seek To Address Quality and Remove Barriers

Instead of reducing eligibility for psychiatric rehabilitation services for children, we encourage you to consider the policy solutions that address the quality of care in PRP-M settings, while also working to remove long-neglected barriers to enhancing other service alternatives for children. We urge you to consider alternatives such as:

- Require the LBHAs to conduct on-site visits for all new applicants for PRP-M licensure;
- Require the ASO to review claims history during a PRP authorization request and, if the child does not have current therapy claims, require the provider to submit additional evidence of medical necessity;

¹ See SAMHSA, "[Maryland 2019 National Outcome Measure \(NOMS\): SAMHSA Uniform Reporting System](#)," at p. 16 (reflecting 4,905 (13%) admissions to state psychiatric hospitals, inpatient units, or residential treatment centers, with 33,607 (85%) admissions to community placements for Maryland children, compared to national admissions of 86,149 to hospital or RTC (0.9%) annually, against 10,113,081 community admissions (99%)).

² While the Medicaid State Plan Amendment for 1915(i) has repeatedly projected utilization by 200 children, the state's estimated expenditures indicate that utilization is planned for no more than 30 children. See, e.g.,

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- Where utilization or auth practices by a PRP-M provider raise concerns, require the ASO to subject the provider to a more frequent authorization schedule and require additional evidence of medical necessity;
- Publish a report annually, available to stakeholders, with data about the utilization of each child service in the public behavioral health system;
- Take steps to convene child stakeholders to discuss barriers to care in the 1915(i) program, and develop a plan to address them;
- Create additional interventions, paid at appropriate rates, to support in-home supports to children.

Thank you for consideration of our request and feedback. If you have any questions, please do not hesitate to contact me at shannon@mdcbh.org.

Sincerely,

Shannon Hall
Executive Director

cc: Dr. Maria Rodowski-Stanco