March 16, 2021

Maria Rodowski-Stanco, M.D.
Director, Child, Adolescent and Young Adult Services
Behavioral Health Administration
Maryland Department of Health

Dear Dr. Rodowski-Stanco:

This letter reflects the concerns of the Community Behavioral Health Association of Maryland (CBH) on the state's new service combination exclusions for psychiatric rehabilitation programs serving children and youth (PRP-M).

Optum released a notification March 1, 2021, that lists child services that cannot be delivered in combination with PRP.[1] This list includes respite services and all levels of targeted case management (TCM). These exclusions reduce access to critical services for children, youth and families during the high stress time of the pandemic, amid the operational chaos of Maryland's ASO, without an implementation plan to develop an adequate array of higher-level services, and without a transition plan for children currently enrolled in concurrent services.

CBH respectfully requests that BHA rescind the March 1st policy until the above concerns can be addressed. Our concerns are discussed in greater detail below.

Recommendation 1: Rescind March 1 policy until known barriers to accessing other levels of care are eliminated.

BHA has indicated a desire to increase utilization of TCM and 1915(i) services, while reducing inappropriate utilization of PRP-M. CBH shares that goal, but the March 1st policy risks achieving the exact opposite of BHA's goal.

TCM and 1915(i) services are both underutilized. Just two percent (2%) of eligible recipients received TCM services in FY18.[2] Fifty-four (54) children

[1] Optum Maryland, "Provider Alert: Updates to Medical Necessity Criteria for Psychiatric Rehabilitation Programs for Minors" (March 1, 2021).
[2] MDH, Report on Behavioral Health Services for Children and Young Adults, pp. 14, 17.

were enrolled in 1915(i) services in FY18, a number which has since decreased despite Maryland's 2014 projection that it would serve between 500 to 750 children per year.[3] CBH has shared with BHA several barriers identified by providers that drive the under-utilization of TCM and 1915(i) services, including referral volume, credentialing, and other issues. No actions have been implemented by BHA to date that address those concerns.

If families are forced to choose between PRP and TCM, there is no way to anticipate which service a family will choose to forfeit. Families are just as likely to continue with PRP services and give up TCM as the other way around, which would result in the opposite impact of the state's desired goal. Likewise, families will lose access to respite services if PRP is the service received by their child that makes them eligible for respite, making the only logical option to forfeit respite services and retain PRP.

No time is right to remove critical supports for children and families without a Plan B, but doing so amid the high stress time of the pandemic poses even greater risk of crisis and inappropriate use of emergency care at a time when hospital visits increase risk of contracting COVID-19 and hospital staff can least afford to divert resources from those ill with the virus.

Recommendation 2: Modify March 1st policy by describing intended rules for each level of care and clinical justification for exceptions.

The state's decision to restrict the concurrent use of PRP with TCM and Respite Care comes at a time when its policies and oversight capabilities are in disarray due to Optum's dysfunctions. This disarray and Optum's history of unreliable implementation warrants revisions to the proposed PRP exclusion policy to offer greater clarity and transparency.

The absence of clear policy guidance to the provider and stakeholder community is compounded by the absence of current utilization data from Optum, provider complaints about Optum's inconsistent and poor implementation of policy changes, and providers' ongoing inability to speak directly with Optum clinicians making authorization decisions.

Allowing clinical authorization of concurrent PRP and TCM or Respite in undefined circumstances, is insufficient. Providers and families have no guidance on when and why concurrent utilization will be authorized, nor any ability to hold Optum accountable if its staff fail to apply exceptions rationally or as clinically appropriate. The state's elimination of "routine" service combinations, not otherwise defined, forces providers to routinely request exceptions via a clinical override of stated policy-- a clear exploitation of the "exception" process. Additionally, an overreliance on the exception option

[3] Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs STATE AND COMMUNITY PROFILES, p. 33

exacerbates the current challenge with receiving timely authorization approvals from Optum, delaying service provision to children and families in need of immediate support.

Recommendation 3: Modify March 1st policy by describing a plan and timeframe *in writing* for transitioning children currently receiving concurrent services that would be prohibited.

Responsible policy planning must account for the fact that some children and families currently receive PRP in conjunction with services that would be prohibited under the March 1st policy. We recommend that BHA develop a clear and transparent transition plan with Optum and providers to ensure that impacted children have the opportunity to seek and obtain clinical exceptions from Optum and/or effectively transition to alternative services.

To date, there exists no plan in writing and the information remitted verbally by Optum at the 3/12/21 provider council meeting—that existing authorizations for PRP, and service delivered in combination with PRP, will be allowed to run until their end date—means that children and families with authorizations for more than one service that happen to end very shortly will have little to no window for transition planning. Instead, we recommend a three-month transition period that includes planning with all key stakeholders around the table to ensure clear communications, coherent planning, and effective implementation.

Recommendation 4: Modify March 1st policy by allowing concurrent delivery of respite and PRP-M.

Unlike PRP, which is a therapeutic service delivered to a child, respite is designed as a support *for caregivers*. MDH's FY18 Report on Behavioral Health Services for Children and Young Adults describes respite care as, "services…designed to provide a break to family caregivers from the stress of caring for a child with behavioral and emotional challenges. These services increase the likelihood that children and young adults will be able to remain in their homes while receiving mental health support rather than being placed in out-of-home settings."[4]

Respite care cannot be considered to duplicate PRP as the target service recipients are different. In fact, in order for a caregiver to be eligible to receive respite services, their child must be receiving mental health treatment. Given that most children receiving only outpatient therapy do not have needs so complex for a caregiver to require respite care, the vast majority of caregivers who would need respite services have a child in a higher level mental health service such as PRP.

[4] FRIENDS National Center for Community-Based Child Abuse Prevention, https://friendsnrc.org/prevention/respite/

Friends National Center for Community-Based Child Abuse Prevention notes "respite rarely operate(s) in isolation, but rather as a critical component of comprehensive family support services or child abuse prevention strategies."[4] In other words, this service works most effectively as an essential component of a combination of supports designed to improve family stability, and prevent crisis and out of home placement. **To remove access to therapeutic services is to not only diminish the utility of respite care, but to eliminate one of few services rendered to a child which would make the caregiver eligible for respite in the first place.**

Recommendation 5: Modify March 1st policy by allowing concurrent delivery of TCM and PRP.

TCM is a coordination service which has historically been delivered in combination with therapeutic services such as PRP, for children with intensive behavioral health needs. PRP is one of the clinical services that providers of TCM help children and their families to access, engage in, and coordinate alongside other treatment and supports.

In Maryland, the Medicaid state plan indicates that one of the eligibility criteria for TCM is whether a participant "needs care coordination services to obtain and maintain community-based treatment and services."[5] The state plan indicates that the "care coordinator shall assure that the participant … *is receiving* the necessary services available to meet the participant's needs as identified in the POS [plan of care]." **To remove PRP from the range of services that can be planned and accessed through TCM is a limit on the state plan service which defeats TCM's purpose of comprehensive planning.**

In conclusion, CBH supports the state's goal of strengthening the continuum of care, ensuring that children with acute needs receive the right level of service and those with less acute needs receive only the services which are medically necessary for them. We do not believe that the March 1st policy meets the state's goal, nor does it provide the level of responsible planning and implementation to ensure that inadvertent harms to children and family is minimized. We strongly urge you to rescind the policy pending a more complete plan developed with stakeholder engagement.

Thank you for consideration of our request. If you need any additional information, please do not hesitate to contact me at lauren@mdcbh.org.

Sincerely,

[5] Medicaid State Plan, Supplement 3 to Attachment 3.1-A at p. 10-I.

Lauren Grimes
Assistant Director
Community Behavioral Health Association of Maryland

cc: Aliya Jones, Deputy Secretary for Behavioral Health, Maryland Department of Health
Shannon Hall, Executive Director, CBH