HB 322 – Public Health – Home- and Community-Based Services for Children and Youth

Committee: Health and Government Operations
Date: February 21, 2023
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling challenge.

MCF strongly supports HB 322.

HB 322 takes a number of steps to improve home-and community based services for children and youth in Maryland. First and foremost, it would restore the delivery of high-fidelity Wraparound, which Maryland had until 2016. What is high-fidelity Wraparound? It is the gold standard of care for children and youth with more intensive mental health needs. It is an evidence-based practice, and like all evidence-based practices, it needs to be practiced with fidelity to the model in order to produce the desired outcomes.

High-fidelity Wraparound is essentially a model of providing care coordination. At its heart, it presupposes that caregivers and children know best what they need to be successful, so plans of care should be ***family driven and youth guided***. The child and their family members work with a Wraparound facilitator to build their Wraparound team, which can include extended family members and friends, as well as various providers of services and supports.

With the help of the team, the family and child develop a Plan of Care which is to be completely **individualized**, with services and supports that will help them achieve their goals. Team members work together to put the Plan of Care into action, **monitor** how well it is working, and **change it as needed**.

In 2019, SAMHSA did a survey of states to determine which ones had well-functioning high-fidelity Wraparound programs. There were 10 states that had been fully implementing the program for an extended period of time, including Georgia, Louisiana, Oklahoma, Texas,

Massachusetts and Pennsylvania) and another 20 states that were well into the process of implementing Wraparound. In all, 40 states replied to the survey. Maryland did not.

States and jurisdictions that have implemented high-fidelity wraparound have seen dramatic results: in Maine there was a 43% decline in inpatient costs and a 29% decline in residential treatment center expenses. Massachusetts saw a 74% decline in inpatient expenses and 32% lower emergency department expenses. Milwaukee Wisconsin went from having 5,000 kids a year in inpatient hospitalizations to just 200. The data is compelling.

In Maryland, the Targeted Case Management (TCM) and 1915(i) programs were instituted in 2014 with the goal of providing wraparound services through a Medicaid State Plan Amendment, so that the services would be Medicaid-reimbursable. Unfortunately, these programs have not been working very well for a variety of reasons:

- Rates are insufficient for the delivery of high-fidelity Wraparound, resulting in inadequate training and high turnover of Care Coordinators, and a failure to assess how well services are being provided with fidelity to the Wraparound model. The programs can sometimes be little more than watered down, cookie-cutter, care coordination.
- The eligibility bar has been set very high. Previously, a youth had to have three inpatient hospitalizations in the last year to be eligible for TCM Level 3 or the 1915(i), and for the 1915(i), meet family income requirements: under 151% of FPL. Eligibility was recently reduced to two inpatient hospitalizations or emergency department visits, and the income criteria was loosened, but the bar is still too high.
- Rates to provide evidence-based practices for youth in the 1915(i) have been prohibitively low, so evidence-based practices, such as Family Centered Treatment and Functional Family Therapy, are not being used.

HB 322 would address these issues.

In addition, in order to develop successful Plans of Care, families must have access to flexible dollars to fund items that are not Medicaid-reimbursable. Things such as martial arts classes for a child with low self-esteem, art therapy for children who are having difficulty expressing themselves, tutoring for youth who are struggling in school, and equine therapy for children who have suffered trauma. When rolling out the TCM and 1915(i) programs, BHA recognized this need for flex funds to fund "Customized Goods and Services," and made a commitment to finding dollars for this. These dollars have been variable, however, and in some years have come close to running out. **HB 322 would set in the budget fixed funds for Customized Goods and Services**, which are key to developing individualized Plans of Care.

Before 2016, when Maryland did have a high-fidelity Wraparound program (paid for with federal grant dollars and state general funds), 300-400 children and youth/year were served. When the MDH developed its State Plan Amendment for the 1915(i), they projected that 200 children and youth/year would be served. The numbers have been significantly lower than this, running between 10 and 40 children and youth/year. In part because the eligibility bar was set so high, but also because the rates have been so low that the services that were supposed to be offered are not being provided:

- Intensive in-home service providers in some places are covering wide areas and so they are providing services virtually. This is not intensive in-home.
- Mobile crisis services, which were supposed to be part of the 1915(i) service array, were removed from the list and are no longer offered.
- There aren't enough respite service providers. Many families can't access the service.
- There are no providers of experiential therapies.

Therefore families have been told not to bother applying for the 1915(i), since there would be little or no benefit to them.

The consequences of not offering a robust community-based services program are many. Youth are unnecessarily going into institutional placements, and then get stuck there. Kids are stuck in emergency departments for days or weeks or even months because there is no place to send them. Kids are stuck in hospital psychiatric inpatient units because an adequate discharge plan cannot be developed. Kids are stuck in residential treatment centers because they too cannot access an adequate discharge plan. Maryland has been relying on costly non-community based settings as a consequence of not adequately addressing the problems with the 1915(i).

HB 322 would begin to address some of the many problems with the 1915(i) and TCM programs. Therefore we urge a favorable report.

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