SB 696 Pediatric Hospital Overstay Patients - Supp

Uploaded by: Andrew Nicklas

Position: FAV

Maryland
Hospital Association

Senate Bill 696- Public Health - Pediatric Hospital Overstay Patients

Position: *Support*
February 18, 2025
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to testify in support of Senate Bill 696.

Maryland hospitals continue to face challenges with children and youth staying in emergency departments and inpatient units beyond medical necessity. This means a medical professional has deemed the patient ready for discharge, but the patient is unable to be discharged home or be transferred to a lower level of care like a residential treatment center.

Since 2018, MHA has worked to address this issue by studying the reasons for these discharge delays, the demographics of these patients, and the unique challenges children and transition-age youth face – especially those in foster care who tend to experience longer delays.

Currently, approximately 43 children across Maryland are stuck in hospitals, with nearly 20% of them in Emergency Departments.

- Approximately 75% of these youth are between the ages of 6 to 17
- Approximately 50% are involved with the Department of Human Services/Local Social Services Agencies
- Approximately 75% are waiting to be placed in Residential Treatment Centers, Foster Homes or Group Homes
- The average length of stay in an inpatient unit *after* being cleared for discharge is 31 days

Hospitals are qualified to deliver care to meet the *acute* needs of children and youth. However, utilizing hospitals as a long-term placement option for days, weeks, months, and, in some extreme cases, a year or more, presents numerous challenges and concerns.

Children and youth who end up "living" in hospitals experience instability, miss school, are isolated from friends and family and have limited access to the outdoors. They live in stark clinical settings surrounded by sick and injured patients, grieving families, and busy medical staff. Having a child stuck in an emergency department also presents challenges since bed space is often limited, and the medical staff caring for these children and youth are needed to treat life and death emergencies.

SB 696 takes concrete steps to ensure that children are not left waiting in a hospital without the care and support they need by taking the following actions:

- Funds Critical Services – Expands residential treatment center (RTC) capacity to address the severe shortage of available placement options. MHA's data show the majority of youth are waiting for placement in an RTC.
- Expands Access to Treatment – Ensures state hospitals also participate in the Maryland Mental Health and Substance Use Disorder Registry to provide transparency into the available beds across the state
- Coordinates State Efforts – Establishes a Pediatric Hospital Overstay Coordinator within the Governor's Office for Children to advocate on behalf of the children and streamline placement efforts. Sometimes youth are connected to multiple state agencies, making it confusing to know which agency is ultimately responsible for the youth. In other cases, if a parent or guardian is not engaged or responsive and no state agency has custody of the child, they are stuck in limbo with no dedicated advocate. The Pediatric Hospital Coordinator will serve as a single point of contact to advocate for the appropriate placement of all children stuck in hospitals.
- Removes Barriers to Placement – Allows hospitals to explore both in-state and out-of-state options simultaneously to avoid unnecessary delays in finding appropriate placements
- Improves Data and Transparency – Mandates an annual report to track progress and identify gaps. The Coordinator would be responsible for reporting to the Governor, House Health & Government Operations Committee, and Senate Finance Committee.

In short, investing in the behavioral health continuum is the only way to ensure children receive the care they need in the most appropriate setting. Transitioning youth into a lower-cost, more appropriate clinical setting will also result in cost-savings for the state in the long term.

SB 696 is not a silver bullet to solve all of the challenges within the behavioral health continuum of care. However, this legislation offers a solution that would have an immediate impact on youth who are stuck in Maryland hospitals right now.

For these reasons, we ask for a favorable report on Senate Bill 696.

For more information, please contact:
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SB0696_MHAMD_Fav.pdf
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MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 696 – Public Health – Pediatric Hospital Overstay Patients
Senate Finance Committee
February 18, 2025
Position: FAVORABLE

Mental Health Association of Maryland (MHAMD) is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in strong support of SB 696.

SB 696 would do several things to begin to address the pediatric hospital overstay issue. The requirements of the bill would serve to both reduce the number of children and youth currently in hospital overstay status and set the stage for further reductions in the future, by directing the Department of Health to review the reimbursement rates for residential treatment centers (RTCs), as well as look at alternate payment models.

The problem of youth in hospital overstays is significant. Complete data is hard to come by, but in 2022, the Maryland Hospital Association reported a weekly census of 50 youth in overstay status, as reported by a total of 39 hospitals.[1] The problem of overstays has far-reaching consequences. Youth stuck in psychiatric inpatient units cause more youth to be stuck in emergency departments, which are ill-equipped to address their needs and horrible places for a child to linger, leading to increased emotional distress. Youth stuck in inpatient units also do not receive the appropriate level of care, or education, or even the ability to go outside. Finally, overstays result in financial losses for hospitals.

There are multiple reasons for this crisis. Over the last decade, Maryland has lost a tremendous number of RTC beds, either due to the closing of facilities or due to staffing problems, and there has been an increasing (and legitimate) reluctance to place youth in out-of-state facilities. At the same time, the availability of robust, intensive community-based services for youth with more serious behavioral health conditions has declined. Not surprisingly, the result has been children and youth stuck in hospital emergency departments and inpatient psychiatric units.

Since 2016, four Maryland RTCs have closed. There are currently six RTC facilities in Maryland, but one is highly specialized – serving only youth in the custody of DJS who have been adjudicated sex offenders with mild developmental disabilities. The five remaining facilities

[1] Not all hospitals reported data, and some youth are stuck in hospitals outside of Maryland. Maryland Hospital Association. Pediatric hospital overstay data collection project (2022). https://mgaleg.maryland.gov/cmte_testimony/2022/app/14I-S_o5hYUDorM40m8F6EtEtBpcAyyUF.pdf

report monthly capacity and vacancy totals. **The last report, for November 2024, indicated that the five facilities had 317 licensed beds, but only 207 operational beds.** The difference is largely due to staffing issues. The combination of low salaries along with very challenging work and an overall behavioral health workforce crisis has made it extremely difficult for RTCs to operate at anywhere near capacity. Simply increasing the number of beds will have little effect – salaries for RTC employees must increase, and the behavioral health workforce crisis must be addressed.[2]

Moreover, Maryland's RTCs don't currently have the capability to appropriately address the serious and complex needs of youth who are stuck in hospitals. These youth require high staffing levels, specialized services, and enhanced security measures so that they can be safe and receive effective treatment. Medicaid, the funding source for most children and youth in RTCs, does not provide sufficient reimbursement for RTCs to adequately address the needs of these children. For these reasons, Maryland RTCs are unable to accept most of the youth who are in hospital overstay status.

The various components of SB 696 – expanding the Registry and Referral System, allowing hospitals to consider out-of-state placement options, adequately funding the RICAs (the state RTCs) so that they can fill all positions, and creating an Overstay Coordinator position within GOC to coordinate care, create and manage data, and recommend needed changes – all will help to tackle the hospital overstay crisis, but there are additional measures that should be taken:

1. **Expand crisis services that are designed specifically for youth and families**. This keeps youth out of hospitals in the first place, by deescalating crises and providing intensive in-home supports to parents and caregivers. The Mobile Response and Stabilization Services (MRSS) model is the gold standard for serving kids, and Maryland piloted several MRSS programs with ARPA dollars, but as these funds are expiring, additional funds are needed from the State.
2. **Support MDH's efforts to improve and expand intensive community-based mental health services.** MDH has drafted a new 1915(i) State Plan Amendment to substantially reform the existing poorly performing 1915(i) program. Robust community-based services both prevent youth from requiring RTC level of care and allow youth currently in RTCs to be successfully and more rapidly discharged, thereby increasing RTC capacity.
3. **Increase reimbursement rates for RTCs and explore alternate payment models.** As SB 696 directs, MDH should develop ways to adequately reimburse facilities so that they can appropriately serve youth with highly acute behavioral health needs.

Therefore MHAMD urges a favorable report on SB 696 and also asks that further actions be considered.

[2] See the recommendations of the Maryland Workforce Assessment Report (October 2024), required by 2023 legislation HB 418/SB 283 https://marylandmatters.org/wp-content/uploads/2024/11/Full-Report_Maryland-BH-Workforce-Assessment-_Final-Oct-2024.pdf

SB 696.pdf
Uploaded by: Ashley Clark
Position: FAV

MARYLAND PSYCHIATRIC SOCIETY

February 11, 2025

The Honorable Pamela Beidle
Chair, Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

RE: Support – SB 696: Public Health - Pediatric Hospital Overstay Patients

Dear Chairwoman Beidle and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1100 psychiatrists and physicians currently in psychiatric training.

Hospitals are not designed for long term stays, especially for children. Prolonged hospitalization can negatively impact their emotional, social and educational development. A safe residential placement allows them to grow in a more nurturing environment. Keeping children in hospitals longer than needed, takes up valuable medical resources such as beds and staff, that could be used for acute care patients who need immediate medical attention. Many families struggle with the emotional and financial burden of having their child hospitalized for an extended period. Laws that ensure safe residential placement can ease this burden by providing stable alternatives. Some children may fall through the cracks and be placed in institutions rather than in family-like settings that promote their well-being and independence. It is more expensive to treat medically stable children in hospital settings than least restrictive environments. Appropriate resources should be put in place to ensure that children who are no longer in need of acute medical care, can be transferred to less expensive, lower level of care that meets their needs.

As such, MPS and WPS ask the committee for a favorable report on SB 696. If you have any questions regarding this testimony, please contact Lisa Harris Jones at lisa.jones@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

SB696_SPHS_Etheridge.pdf
Uploaded by: Carrie Etheridge
Position: FAV

Sheppard Pratt

Oral Testimony – Carrie Etheridge-FAV

Senate Bill 696 – Public Health – Pediatric Hospital Overstay Patients

Senate Finance Committee

February 18, 2025

Madame Chair, Vice Chair Hayes, and members of the Senate Finance Committee,

Thank you for the opportunity to testify on this critical bill. I also thank the Chair for recognizing its importance. My name is Carrie Etheridge, and I am the Director of Social Work at Sheppard Pratt. I am here to share my firsthand experience in hospital, inpatient psychiatric, and residential treatment center (RTC) processes to highlight the challenges our pediatric patients and care providers face daily.

Impact and Dangers of Children Staying in Hospital Beds Longer Than Necessary:

- Emotional and psychological harm: Extended hospital stays without appropriate therapeutic care exacerbate anxiety, depression, and behavioral deterioration. **Our acute settings are meant to stabilize and get patients to a less restrictive setting such as day hospitals, outpatient therapy or RTC's. The level of therapeutic intervention provided in such settings is critical to maintaining the progress and health of the most vulnerable children in our state. A locked inpatient psychiatric unit is meant to be brief, not months and sometimes years simply because they have nowhere to live.**

- Developmental setbacks: Children miss critical educational and social development opportunities when confined to a hospital setting. **While home and hospital is utilized, it does not remotely meet the needs or expectations of a full academic day, occurring a few hours a week at best depending on tutors schedules.**
- Trauma exposure: Being hospitalized for extended periods can be retraumatizing, leading to worsening mental health conditions**. Knowing you are abandoned, and no one is coming to pick you up whether that is your family or your DSS worker is incredibly demoralizing for a teen who has already been abandoned by so many parts of the community and system. Watching other kids come and go, families visit and pick up their peers is incredibly destabilizing.**

- Increased aggression and crisis incidents: Many children decompensate in hospital environments, leading to escalated behaviors requiring more intensive interventions. **It is a vicious cycle of re-traumatization that occurs when kids feel hopeless and see no end in sight. When there is no hope of getting out of the hospital no matter how stable and positive your behaviors and functioning are currently, they reengage in maladaptive behaviors. This negates all of the progress made for months when they could have left the hospital, but were not able to simply because they had nowhere to go, not because they needed to be in a locked inpatient psychiatric facility for their care and safety.**

Diversion of Resources & Impact on Hospital Operations:

- Hospital beds are blocked: Overstay patients occupy beds that could serve other children in psychiatric crises.
- Strain on emergency departments: Hospitals must hold children in emergency rooms while inpatient beds remain full, delaying care for new admissions.
- Increased staffing burden: Extended stays require hospital staff to provide long-term care without the specialized resources needed for rehabilitation.
- Financial and operational strain: Hospitals must allocate resources for non-acute care rather than crisis stabilization, impacting overall efficiency.

The burdensome processes in place that are ineffective, time consuming and broken exacerbate these issues. Waiting for the VPA process, CPS/DSS to reply to abandonment report when patient is not picked up by parent, waiting for group homes and RTC's to have the staffing even if a bed is available, and absolutely no recourse or consequence for families that refuse to pick up their children such as an automatic CINA hearing adds to the delays and travesty that these children face. We have lost placements and beds that a child is ready to go to because of red tape and ill created state systems that don't talk to each other and don't meet the needs of Maryand's most vulnerable.

Sheppard Pratt fully supports efforts to address pediatric hospital overstay challenges and enhance care coordination. Ensuring a robust continuum of care benefits not just overstay patients but the entire behavioral health system.

For these reasons, Sheppard Pratt urges a **favorable report on SB696**.

SB0696_FAV_MedChi, MDACEP_PH - Pediatric Hospital

Uploaded by: Danna Kauffman

Position: FAV

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Senate Finance Committee
February 18, 2025
Senate Bill 696 – *Public Health – Pediatric Hospital Overstay Patients*
POSITION: SUPPORT

On behalf of MedChi, The Maryland State Medical Society and the Maryland Chapter of the American College of Emergency Physicians (MDACEP), we submit this letter of support for Senate Bill 696.

Senate Bill 696 expands the Maryland Mental Health and Substance Use Disorder Registry and Referral System to include both private and state inpatient and outpatient services. It mandates the Maryland Department of Health, in coordination with the Department of Human Services, to ensure that pediatric hospitals overstay patients – those who remain in hospitals beyond medical necessity – are placed in the least restrictive setting possible. Hospitals are authorized to explore both in-state and out-of-state placements for these patients. Additionally, the bill establishes a Pediatric Hospital Overstay Coordinator within the Governor's Office for Children to coordinate efforts between state agencies, advocate for pediatric hospital overstay patients, and maintain data on their cases. The bill includes funding provisions for filling positions at regional institutes for children and adolescents and mandates annual reporting on pediatric hospital overstay cases.

Pediatric hospital overstays have been a persistent issue in Maryland, particularly affecting foster children. On February 6, 2025 the Department of Human Services released their *Report on Hospital Stays, Average Length of Stay, and Placements After Discharge*, which was completed pursuant to the *2024 Joint Chairmen's Report*. According to the report in FY 2024, 102 youths in the care of local departments of social services experienced hospital overstays. These children often remain in hospitals for weeks or even months beyond medical necessity, facing emotional and developmental challenges as a result. These overstays occur due to gaps in community-based and residential services, highlighting the need for improved placement options, which this bill aims to address. For these reasons, MedChi and MDACEP support Senate Bill 696.

For more information call:
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Children's National Testimony - SB 696 - Jennifer
Uploaded by: Jennifer Dorr
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Testimony of Jennifer Dorr, DO, MPH
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SB 696: Public Health - Pediatric Hospital Overstay Patients
Position: FAVORABLE
February 18, 2025
Senate Finance Committee

Chair Beidle, Vice Chair Hayes and members of the committee, thank you for the opportunity to provide testimony in favor of Senate Bill 696. My name is Jennifer Dorr, DO, MPH, and I am a child and adolescent psychiatrist at Children's National Hospital. Today, I am representing and speaking on behalf of Children's National and on behalf of both the Maryland Psychiatric Society and the Washington Psychiatric Society. Children's National has been serving the nation's children since 1870. Nearly 60% of our patients are residents of Maryland, and we maintain a network of community-based pediatric practices, surgery centers and regional outpatient centers in Maryland.

Senate Bill 696 aims to have pediatric patients admitted to the least restrictive environment appropriate for their clinical needs. With the establishment of a Pediatric Hospital Overstay Coordinator, and a subsequent study to be conducted of residential and other facilities, this bill has a strong aim and is very important to the quality of life of our pediatric patients.

Being on the front lines, I see what devastation can be caused if a child is unable to be discharged from inpatient care when they are either medically or psychiatrically stabilized, simply due to a lack of appropriate disposition. While working on the inpatient unit at Children's National, I encountered a patient we will call Joe. Joe is a 14-year-old individual who had PTSD from significant abuse as a younger child and a genetic syndrome. He had prior hospitalizations to inpatient psychiatry units and struggled with significant suicidal ideation and other mental health struggles and was ready to be transferred to a residential facility after a few weeks inpatient. However, Joe remained on the psychiatric unit for over 5 months while awaiting placement. This not only took a bed from someone who was waiting in the Emergency Department for an inpatient psychiatric bed and was a huge cost to the system, but also this greatly affected the patient's overall mental health. When a child is stabilized either medically or

psychiatrically but must stay in the hospital for months due to the lack of appropriate placement, it is a serious issue. We need to do better for the children of our nation, and especially our state. This is simply unacceptable. It delays a patient getting back to "real life," may halt social, educational, and developmental growth, and can worsen their overall mental health. They may feel trapped, because essentially, they are trapped. A hospital or an inpatient unit is not an appropriate place for a child to grow up in.

I have many other examples of such patients, including a 15 year-old girl who presented to the psychiatric unit due to violence and aggression at home. Then, during her admission it was discovered that she was being abused at home. The patient's mother eventually gave up custody, but the patient remained on the unit (even though stabilized after a few weeks) for 3-4 months. This is not okay, and quite frankly our system is failing our children. What these children and families need is a stable place to be discharged, and many times this is a higher level of care like residential placement, or even a day program. However, when those options are unavailable, the patients and their families suffer. Many times, these families may be able to be kept together with family and parenting work as an outpatient, but those resources are often not available.

Please help us as child and adolescent psychiatrists help our patients and families. Please don't continue to put us in a position of keeping a child admitted to the hospital simply because there is not an identified place for that child to go. Let's all together stop punishing our children and families who come to the hospital for help, only to then have to remain there for sometimes over a year. Let's not continue to give them significant emotional and financial trauma. Let's do better for our children.

I applaud Chair Beidle for introducing this important legislation, which will have life-long benefits for our state's youngest residents and respectfully request a favorable report on SB 696. Thank you for the opportunity to submit testimony. I am happy to respond to any questions you may have.

For more information, please contact:
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LBH FAV Senate Bill 696- Public Health - Pediatric
Uploaded by: Jennifer Witten
Position: FAV

LIFEBRIDGE HEALTH®

Date: February 18, 2025
To: Chair Beidle, Vice Chair Hayes and the Senate Finance Committee Members
Reference: Senate Bill 696- Public Health - Pediatric Hospital Overstay Patients

Position: Favorable

Dear Senate Finance Committee Members,
On behalf of LifeBridge Health, we urge your strong consideration for Senate Bill 696. LifeBridge Health is a regional health system comprising Sinai Hospital of Baltimore, an independent academic medical center; Levindale Hebrew Geriatric Center and Hospital in Baltimore; Northwest Hospital, a community hospital in Baltimore County; Carroll Hospital, a sole community hospital in Carroll County; Grace Medical Center (formerly Bon Secours Hospital), a freestanding medical facility in West Baltimore; and Center for Hope a center of excellence focused on provided hope and services for trauma survivors in Baltimore City.

Pediatric patients being "boarded," or kept waiting for transfer in emergency departments (ED), are stuck waiting sometimes for days and weeks due to complexity of our current system and the shortage of open inpatient beds in the state, and an even greater lack of community options for placement that serves youth with co-occurring developmental, medical, and behavioral health conditions. Some of these youths are under custody of the state, while many are unfortunately left by parents who simply cannot manage the child's needs and have no other option.

LifeBridge Health hospitals face ongoing challenges with children and youth staying in emergency departments and inpatient units well beyond medical necessity. In just the last couple of months our hospitals had over sixteen pediatric patients (ages twenty-one and under) that have had a length of staff in the emergency room over 24 hours past assessment. Of those youth assessed five have been in the ED for over 60 days, eight have been there greater than 7 days. Most of these patients were brought to the ED by a parent or guardian, one escorted by courts and one by law enforcement. We had a pediatric male patient last year who was at one of our emergency rooms for over 150 days.

Children and youth who live in hospitals often experience instability, miss school, are isolated from friends and family, and have limited access to essential services. Their ability to go outside and participate in activities is also restricted. Additionally, they live in clinical environments with unfamiliar sounds and smells, lacking the comfort of a home-like setting. Especially in the emergency department, staying for a longer length of time can be challenging since bed space can be limited, medical staff caring for these children and youth are needed to treat life and death emergencies. This environment is not therapeutic for extended time periods and can escalate a situation. These experiences have a negative impact on all those involved including the child and the staff.

The ability of state agencies, like SSA, to expand access to appropriate placements is critical. These children and youth deserve to live in appropriate settings, which are licensed to meet their needs. When appropriate placements and service providers are not available, these children and youth can end up lingering in inappropriate settings like hospitals and hotels, waiting for a placement.

Alternatively, some children and youth are sent out of state when no providers or placements are available to meet their needs. Both scenarios are not sufficient to meet the needs of Maryland's children, youth, and families. We need to ensure that we have an ombudsman who can advocate on behalf of the child and capacity to offer the optimal placement to continue the therapy and oversight to support a child's recovery.

Senate Bill 696 does not solve this complex issue; however, it would make a significant positive impact on our ability to truly serve children and their families. The bill seeks to achieve the following.

- **Funds Critical Services** – Provides funding to staff and maintain more beds in residential treatment centers, addressing the primary cause of pediatric overstays: a severe shortage of available placement.
- **Expands Access to Treatment** – Ensures that the Maryland Mental Health and Substance Use Disorder Registry includes both private and state services, helping families and providers find appropriate care faster.
- **Coordinates State Efforts** – Establishes a Pediatric Hospital Overstay Coordinator within the Governor's Office for Children to ensure timely placements.
- **Removes Barriers to Placement** – Allows hospitals to explore both in-state and out-of-state options to place children in the most appropriate setting.
- **Improves Data and Transparency** – Mandates an annual report on pediatric hospital overstay patients to identify gaps and track progress.

With all these considerations, we urge a favorable report on Senate Bill 696.

For more information, please contact:
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UPMC Western Maryland SB0696.pdf
Uploaded by: Kathryn Whitacre
Position: FAV

UPMC LIFE CHANGING MEDICINE

UPMC Western Maryland
12500 Willowbrook Road
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Good afternoon and thank you Chair Beidl and Vice Chair Hayes for the opportunity to address the Committee, and for your timely concern and attention to this issue.

My name is Kathyrn Whitacre, Director of UPMC Western Maryland Behavioral Health Services, located in the rural region of Cumberland, Maryland. We serve residents in Allegany County and the surrounding counties in Maryland, West Virginia, and Pennsylvania.

UPMC Western Maryland is always working to improve access and coordination of care for behavioral health services. We are increasing access points for individuals to be connected to the right level of care across the continuum and support the tenets of SB 696 especially the *least restrictive settings* language. To that end, we have embedded behavioral health specialists in primary care offices, enhanced our telehealth capabilities, and strengthen our collaboration with our local and regional partners such as Allegany County Local Behavioral Health Authority – and with the intention of meeting our patients where they are, and where they want to be.

Given our rural location, there are a lack of resources for adolescents and specialty care for patients with aggression or severe autism dx. The bill's provision for MDH to conduct a review of residential treatment center and respite facility rates is MUCH needed. There is also a lack of transportation.

Over the past 2 years, we have experienced several pediatric overstays in our ED with the most recent lasting upwards of 7 weeks (and was issued 33 denials from other hospitals). Although we are fortunate to have a low volume of pediatric overstay incidents, each one traumatically impacts their mental health and delays their ability to receive treatment in the most appropriate care setting. All of this negatively impacts this pediatric patient population.

First and foremost, these children are isolated. The child is stuck inside a hospital room for an extended period. They are not able to go outside, and often do not know what time of day it is due to lack of windows/light. That is considered delirium. Moreover, there are physical health concerns for these children due to limited environment that doesn't allow for exercise. In fact, at times, 1:1 care is needed as well as support from security when they need to sit with the youth for safety reasons. This poses challenges around hospital staffing and throughput issues are exacerbated.

Second, there is no school. The child is missing school, and they are challenged to complete coursework while in the ED. There is limited support from the school system and delays in the process to provide services for those youth boarding with an extended length of stay.

Third, communication amongst agencies is disjointed and often lacking guidance. Often the only feedback we get is to "check the bed board" or there is "nothing we can do for this child."

As a representative of UPMC Western Maryland, I thank you for your time and consideration along with the opportunity to share our concerns from the rural perspective.

We respectfully ask for a favorable report on Senate Bill 696. Legislation - SB0696

SB 696 - Public Health - Pediatric Hospital Overst

Uploaded by: Kimberly Routson

Position: FAV

MedStar Health

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Kimberly S. Routson
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SB 696 – Public Health – Pediatric Hospital Overstay Patients

Position: ***Support***
Senate Finance Committee
February 18, 2025

MedStar Health is the largest healthcare provider in Maryland and the Washington, D.C. region. MedStar Health offers a comprehensive spectrum of clinical services through over 400 care locations, including 10 hospitals, 33 urgent care clinics, ambulatory care centers and an extensive array of primary and specialty care providers. We are also home to the MedStar Health Research Institute and a comprehensive scope of health-related organizations all recognized regionally and nationally for excellence. MedStar Health has one of the largest graduate medical education programs in the country, training 1,150 medical residents annually, and is the medical education and clinical partner of Georgetown University. As a not-for-profit healthcare system, MedStar Health is committed to its patient-first philosophy, emphasizing care, compassion, and clinical excellence, supported by a dedicated team of over 35,000 physicians, nurses and many other clinical and non-clinical associates.

SB 696 addresses the issue of pediatric patients under the age of 22 who remain in hospital inpatient settings or emergency departments for more than 24 hours, after being medically cleared for discharge or transfer. One of the most challenging situations in caring for our communities is when a child is brought to the emergency department, is treated and stabilized, and no longer needs acute care services but cannot find an appropriate placement to discharge the patient. These children often spend days and weeks in the emergency department, and some spend months in our inpatient units while we search for an appropriate placement. MedStar Health has countless heartbreaking stories of youth that lack schooling, proper socialization and emotional engagement while stuck in these inappropriate settings. The bill creates a coordinating function in the Governor's Office for Children that will be crucial to organizing state agencies and programs to drive positive outcomes for these children.

Pediatric overstays can be attributed to several causes: lack of bed capacity and insufficient reimbursement rates, lack of accountability and transparency to support the needs of youth and families in crisis, and outdated processes and administrative burdens that prevent patients from accessing the care they need in a timely manner. Patients experiencing the longest overstays are generally either under the custody of DHS or under a parent's custody but essentially are abandoned in the emergency departments. Furthermore, hospital inpatient psychiatric units also face challenges with long overstays while waiting for numerous state agency approvals for pediatric patients. These overstays are a gross disservice to the children and to the community. As a result, critical beds and resources are not available for acute care patients.

This bill is a necessary step forward in protecting this vulnerable population. Without intervention, these youth will continue to be left behind. The need for coordination efforts, updates from agencies seeking to place the pediatric patients, and a workgroup to determine the least restrictive places are essential to providing care efficiently and addressing issues of health equity and disparities across our state.

For the reasons above, MedStar Health urges a ***favorable*** report on **SB 696**.

SB696 Pediatric Overstays - Johns Hopkins - SUPPOR

Uploaded by: Michael Huber

Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Senator Pam Beidle, Chair
Senate, Finance Committee

FROM: Michael Huber
Director, Maryland Government Affairs

SB696
Favorable

DATE: February 18, 2025

RE: SB696 – Public Health – Pediatric Hospital Overstay Patients

Johns Hopkins University & Medicine supports **Senate Bill 696 – Public Health - Pediatric Hospital Overstay Patients.** This bill seeks to provide more appropriate placements for pediatric overstay patients in Maryland's hospitals. These are patients under the age of 22 who are in hospitals more than 24 hours after it has been determined they do not have any medical reason to remain in a hospital. It does this by creating accountability and capacity. Accountability comes through the creation of a coordinator position to ease administrative burdens for placements and capacity comes from the mandated funding for staffing of existing beds in a more appropriate setting.

The impact of holding children awaiting state placement is significant. Johns Hopkins feels for these children and hope that we can collaborate on a solution that is beneficial for all involved. However, due to the requirement to hold these children, who by definition do not have medical or psychiatric admission needs, we are denying care to others who do. Below we've briefly described the resources required by Johns Hopkins Children Center (JHCC) to care for these patients.

Hospital Bed Utilization
In 2024, we had a total of **1,591** days of boarding. Of these 1,039 days, or 65%, were children awaiting Department of Social Services placement. That equals 3-5 beds out of our total of 80 acute care and 15 inpatient psychiatry beds that were offline for the entire year.

Mental Health Care for DSS Boarders while at JHCC
We provide additional care for these young people when they are here for an extended period of time based on our boarder process. If they are moved to a medical, acute care bed from an Emergency Room bed (typically after 72 hours), we implement a behavioral health plan, and they are seen by psychology personnel weekly. We also assist with the home and health referral for school.

We prioritize the safety of these children under our supervision. When youth are admitted to an inpatient acute care bed due to a lack of safe options in the community, we restrict their ability to leave the inpatient unit to prevent them from eloping from the hospital.

Academic support
They attend, if they choose (we cannot force if they refuse, which some do), academic lessons provided by Baltimore City Public Schools Home and Hospital Program.

Staff support
Additionally, we have weekly care coordination meetings with the Department of Social Services (DSS) teams and Social Security Administration (SSA) to collaborate on placements and their overall needs. Overall, our Social Work team spends an average of six hours a week on each child's care coordination. Nursing also spends an increased amount of time with each child on their behavioral

needs. We have 1:1 staff supervision and security detail, which is an additional cost. Lastly, some of the children have destroyed medical rooms, taking them offline for weeks after they leave. They have broken toilets, sinks, beds, walls, windows, etc. The cost has been over of $30,000 on at least one occasion.

Financial Concerns
While caring for these DSS patients, we have children in medical beds without medical needs. Frequently are writing off $2,500/day to hold these patients. We are providing room and board, nursing, security, medications, etc. without reimbursement for our costs. More critically, they are occupying beds that are desperately needed by children with medical need in our own emergency room and across the state.

Impact of Bed Utilization by DSS Boarding population
As referenced, in 2024, JHCC provided over 1000 bed days of care to children and youth under DSS custody, whose medical condition did not necessitate hospital admission.

During this time, **218** transport calls requesting admission were denied - **218** children in the state of Maryland could not receive urgent medical care at JHCC. Of those patients denied admission to JHCC due to lack of bed availability, **39** required critical care and were airlifted or urgently transported to pediatric care facilities in Washington D.C., Pennsylvania or Delaware. The impact of additional transport time on the survival of these critically ill children cannot be reliably estimated, but we know that additional time is not beneficial for care and outcomes for them. JHCC is the only pediatric Level I trauma/burn center in Maryland and the only pediatric facility in Maryland that provides ECMO, thus the highest acuity of care. Denial of any such need places a life in imminent danger. In 2024, we denied access to JHCC **90** times due to lack of beds.

These resources are extended during the overstay because there is simply not enough appropriate settings for these children to go to. These children need therapeutic, safe environment with the space, education, and resources available to heal and grow. This bill requires the State to make the necessary investments to create these placements and help these children. In the interest of these young people and on behalf of our clinical and social work teams who are responsible for caring for them while they are in our hospitals, we **ask for a favorable report on SB696**.

SB696 Testimony.pdf
Uploaded by: Pamela Beidle
Position: FAV

PAMELA G. BEIDLE
Legislative District 32
Anne Arundel County

Chair, Finance Committee
Executive Nominations Committee

Joint Committee on Gaming Oversight
Joint Committee on Management of Public Funds
Spending Affordability Committee

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February 18, 2025

Senate Bill 696
Public Health - Pediatric Hospital Overstay Patients

Good afternoon, Vice Chair Hayes and Members of the Committee:

I am pleased to present Senate Bill 696 - Public Health - Pediatric Hospital Overstay Patients. SB 696 addresses an egregious problem impacting children and youth across the State.

Every day here in Maryland there are children and youth stuck in hospital emergency departments and inpatient units. As this committee knows, I have been working hard to address the challenges our emergency departments are facing with long wait times. When youth are stuck in an emergency room and unable to transition to a more appropriate care setting to meet their needs, this negatively impacts the child, the hospital staff, and members of the community who need access to emergency services.

SB 696 will not solve all our problems; however, this legislation takes concrete steps to expand the behavioral health capacity we need in the short-term and bring oversight and accountability for placing these youth in the appropriate setting.

The bill does the following:

- Expands residential treatment capacity by directing MDH to staff the licensed but unstaffed state operated residential treatment beds. There are currently 17 of these beds in the state and expanding capacity, even by this much, will make a difference. MDH can use funds currently designated for the Adolescent Hospital Overstay Program to accomplish this.
- Requires state hospitals to participate in the Maryland Mental Health and Substance Use Disorder Registry. Right now, there is not a line of sight into how many open state beds we have, like we have on the private hospital side. This level of transparency will help us better understand bed capacity across the state.
- Establishes a Pediatric Hospital Overstay Coordinator within the Governor's Office for Children to advocate on behalf of the children stuck in hospitals and streamline

placement efforts. This single point of contact will coordinate with hospitals and all relevant state agencies in pursuit of the most appropriate placement option. This Coordinator is also required to report annually to the Governor and the General Assembly on the status of pediatric overstay patients across the state including recommended policy and procedures.

- Lastly, the bill requires the Department of Health to review the reimbursement rates paid to residential treatment centers and respite care facilities for potential reforms that will incentivize the expansion of RTC and respite care facility capacity in the State.

We did not get into this problem overnight, and we will not get out of it overnight. However, passing this bill will allow us to take immediate action to address the needs of children and youth stuck in hospitals across the State.

Thank you for the opportunity to present this legislation to the Committee. I respectfully request a favorable report on Senate Bill 696.

SB 696 - UMMS - FAV (2-18-25).pdf
Uploaded by: Will Tilburg
Position: FAV

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Senate Bill 696 – Public Health – Pediatric Hospital Overstay Patients

Position: Support
February 18, 2025
Senate Finance Committee

The University of Maryland Medical System supports Senate Bill 696 – Public Health – Pediatric Hospital Overstay Patients and requests a favorable report on the bill. Senate Bill 696 ("SB 696") would establish a coordinator within the Governor's Office for Children to support the Maryland Department of Human Services and Maryland Department of Health in transferring and treating pediatric overstay patients, as well as enhancing data collection and reporting on pediatric hospital overstay patients.

This bill begins to address the critical issue of pediatric hospital overstay patients, which affects not only the well-being of our youngest and most vulnerable patients, but also the efficiency and effectiveness of our healthcare system.

The University of Maryland Medical System (UMMS) provides primary, urgent, emergency and specialty care at 12 hospitals and more than 150 medical facilities across the state. The UMMS network includes academic, community and specialty hospitals that together provide 25% of all hospital-based care in Maryland. Our acute care and specialty hospitals are located in 13 counties and Baltimore City, and serve urban, suburban and rural communities.

In recent years, UMMS member hospitals have seen an increasing number of children and youth who are stuck in emergency departments and inpatient units well beyond a period of medical necessity. Since July, the University of Maryland Medical Center in Baltimore City alone has had at least 20 children remain in the hospital for more than 24 hours after medical clearance. These children and youth, who range in age from 1 month to 19 years old, combined for a total of 446 overstay days in an emergency department or inpatient unit. This is just one example from one hospital in our system, but it highlights the growing scope of the problem.

Being forced to stay in a hospital beyond any medical necessity can be a traumatic experience for children and youth. Hospitals are filled with loud and unfamiliar sights, sounds, and smells, and pediatric overstays in a hospital setting are frequently isolated from school, friends, and family, and the comforts of their everyday lives.

The issue of pediatric hospital overstays also has significant adverse impacts on patient throughput and the ability of hospitals to treat sick and injured patients in a timely fashion. Each bed and room occupied by a child or youth who does not have a medical need for it limits the ability of a hospital to treat a patient who is in critical need of care. As many of these pediatric overstays are occupying rooms in emergency departments there is a direct connection between this issue and emergency department wait times.

SB 696 is not a silver bullet and will not solve the complex issue of pediatric hospital overstays alone. However, it will have a significant positive impact on the children and youth who are pediatric overstay patients, as well as the ability of Maryland hospitals to serve these children and youth.

For these reasons, the University of Maryland Medical System strongly supports SB 696 and respectfully requests a ***favorable*** report on the bill.

For more information, please contact:

Will Tilburg, Vice President, Government and Regulatory Affairs
University of Maryland Medical System
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PROPOSED AMENDMENTS TO SB0696 AND HB0962 CPMC 0218

Uploaded by: Diana Philip

Position: FWA

PROPOSED AMENDMENTS TO SB0696 AND HB0962

Page 1, lines 8-9	Delete "authorizing a hospital to concurrently explore in–State and out–of–state placements for pediatric hospital overstay patients; establishing the Pediatric Hospital Overstay and Unlicensed Placement Coordinator within the Governor's Office for Children"
Page 1, lines 9-10	Replace "establishing the Pediatric Hospital Overstay Coordinator within the Governor's Office for Children" with "establishing the Pediatric Hospital Overstay and Unlicensed Placement Coordinator within the Governor's Office for Children"
Page 1, lines 12-13	Replace "and generally relating to pediatric hospital overstay patients" with "requires the Department of Health and the Department of Human Services to conduct a data-driven study of the characteristics and needs of children and youth in emergency departments and hospital overstays, as well as those in unlicensed placements and the contracted beds to serve the children with those needs; develop a comprehensive plan to end the practice of emergency departments and hospital overstays with a report due to the Legislature by December 2025; and generally relating to pediatric hospital overstay patients and children and youth in Department of Human Services custody in unlicensed settings."
Page 1, lines 21-22	Replace "Pediatric Overstay" with "Pediatric Overstay and Unlicensed Settings"
Page 3, line 2	Replace "PEDIATRIC OVERSTAY" with "PEDIATRIC OVERSTAY AND UNLICENSED SETTINGS"
Page 3, line 8	Insert between line 7 and line 8 with "CHILD IN AN UNLICENSED SETTING" MEANS A CHILD IN OUT OF HOME PLACEMENT RESIDING IN HOTELS, OFFICE BUILDINGS, SHELTERS, OR OTHER UNLICENSED SETTINGS EXCLUDING YOUTH RECEIVING SELF- INDEPENDENT LIVING ALLOWANCE STIPENDS, THOSE WITH KIN AWAITING APPROVAL FOR PLACEMENT, OR ON AFTERCARE WITH A PARENT."
Page 3, lines 11-12	Insert between "A PEDIATRIC HOSPITAL OVERSTAY PATIENT" and "IS TRANSFERRED TO AND TREATED" with "OR A CHILD IN AN UNLICENSED SETTING"
Page 3, Line 12	At end of sentence, before period, add ", AND AS SOON AS POSSIBLE"
Page 3, lines 13-16	Delete entire paragraph
Page 3, lines 20-21	Add after "REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS IN THE STATE" with "THAT IS MANDATED TO ACCEPT CHILDREN FROM ALL JURISDICTIONS."

Page 3, lines 26-28 — Replace "THE GOVERNOR MAY USE FUNDS DESIGNATED FOR THE ADOLESCENT HOSPITAL OVERSTAY PROGRAM FOR THE PURPOSES IDENTIFIED IN SUBSECTION (A) OF THIS SECTION" with "THE DEPARTMENT OF HUMAN SERVICES MAY USE FUNDS DESIGNATED FOR THE ADOLESCENT HOSPITAL OVERSTAY PROGRAM AND FUNDS OTHERWISE DESIGNATED TO FUND UNLICENSED SETTINGS TO STRENGTHEN SERVICES AND STAFFING FOR THE PURPOSES IDENTIFIED IN SUBSECTION (A) OF THIS SECTION.

Page 4, line 3 — Insert between "PEDIATRIC HOSPITAL OVERSTAY" and "COORDINATOR" with "AND UNLICENSED SETTINGS".

Page 4, lines 14-15 — Insert between "PEDIATRIC HOSPITAL OVERSTAY PATIENT" and "HAS THE MEANING" with "AND "CHILD IN UNLICENSED SETTINGS"

Page 4, lines 25-26 — Insert between "PUBLIC BEHAVIORAL HEALTH CARE" and "COORDINATION PROGRAMS" with "AND PROGRAMS FOR CHILDREN WITH AUTISM AND OTHER DEVELOPMENTAL DISORDERS".

Page 5, line 2 — Insert between "PEDIATRIC HOSPITAL OVERSTAY PATIENT" and "IN THE STATE" with "AND CHILDREN IN UNLICENSED SETTINGS".

Page 5, line 11 — Insert after "PEDIATRIC HOSPITAL OVERSTAY PATIENTS" with "AND CHILDREN IN UNLICENSED SETTINGS"

Page 5, line 15 — Insert after "PEDIATRIC HOSPITAL OVERSTAY PATIENTS" with "AND CHILDREN IN UNLICENSED SETTINGS"

Page 5, line 19 — Insert between "THE RESPONSIBLE STATE AGENCY" and "IF APPLICABLE" with ", INCLUDING THOSE PATIENTS FOR WHOM A STATE AGENCY HAS RESPONSIBILITY FOR MAKING A PLAN,"

Page 5, line 21 — Replace "PLACEMENT OPTIONS BEING SOUGHT BY THE PATIENT" with "PLACEMENT OPTIONS BEING RECOMMENDED ON BEHALF OF THE PATIENT;"

Page 5, line 23 — Insert between "HEALTH DIAGNOSIS;" and "AND" new paragraphs (VI), (VII), and (VIII):

"(VI) THE CHILD'S AGE, RACE, ETHNICITY, SEX, GENDER, DISABILITY STATUS, EDUCATIONAL NEEDS, COUNTY OF RESIDENCE, AND LOCATION OF LOCAL DSS SERVING THE CHILD;

(VII) PROTECTIVE SERVICES STATUS AND HISTORY, IF ANY;

(VIII) DURATION OF HOSPITALIZATION AND HOSPITAL OVERSTAY STATUS;"

Page 5, Line 24 Change "(VI)" to "(IX)"

Page 5, Line 25 Insert new Paragraph (E):

"(E) WITHIN THREE MONTHS OF THE EFFECTIVE DATE OF THIS ACT, THE COORDINATOR SHALL COMPLETE AN ASSESSMENT OF THE NUMBER, TYPES, AND COST OF THE ADDITIONAL BEDS AND THE SUPPORTIVE SERVICES NEEDED TO PLACE ALL CHILDREN IN PEDIATRIC OVERSTAYS IN THE LEAST RESTRICTIVE PLACEMENT, AS SOON AS POSSIBLE. THE COORDINATOR SHALL MAKE THIS ASSESSMENT BY WORKING WITH REPRESENTATIVES OF

(1) THE MARYLAND DEPARTMENT OF HEALTH

(2) THE MARYLAND DEPARTMENT HUMAN SERVICES,

(3) PRIVATE PLACEMENT PROVIDERS OF FOSTER CARE SERVICES,

(4) PRIVATE PLACEMENT PROVIDERS OF BEHAVIORAL HEALTH SERVICES,

(5) DISABILITY RIGHTS MARYLAND,

(6) THE OFFICE OF THE PUBLIC DEFENDER,

(7) ATTORNEYS WHO REPRESENT FOSTER CHILDREN IN PEDIATRIC OVERSTAYS,

(8) MARYLAND LEGAL AID,

(9) COURT APPOINTED SPECIAL ADVOCATES OF MARYLAND, AND

(10) MArYLAND CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS.

Page 5, Line 25 Change "(E)" to "(F)"

Page 5, line 29 Insert between "PEDIATRIC HOSPITAL OVERSTAY PATIENTS" and "IN THE STATE" with "AND CHILDREN IN UNLICENSED SETTINGS".

Page 5, line 31 Add after "ACHIEVE APPROPRIATE PLACMENT" with ", AND THESE REPORTS SHALL INCLUDE"

Page 6, line 1 Add new paragraphs (1), (2), and (3):

(1) PLANS TO END THE PRACTICES OF CHILDREN RESIDING IN HOSPITAL OVERSTAYS AND UNLICENSED SETTINGS,

(2) DATA THAT INFORMS HOW THE PLANS WILL BE IMPLEMENTED, AND

(3) THE ANTICIPATED TIMELINE WHEN PRACTICES OF CHILDREN RESIDING IN HOSPITAL OVERSTAYS AND UNLICENSED SETTINGS WILL CEASE."

Letter to Senate Fin. Committee re SB 696 (2025).p
Uploaded by: Mitchell Mirviss
Position: FWA

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February 14, 2025

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Senator Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

Re: **SB 696 (2025): SUPPORT WITH AMENDMENTS**

Dear Chairwoman Beidle and Members of the Committee:

I support SB 696, "Public Health – Pediatric Hospital Overstay Patients," but with amendments, and urge the Committee to issue a favorable report *if* SB 696 is amended. My line-edits of proposed amendments are submitted as Attachment 1.

My interest in this issue is strong. I am co-class counsel for the class of Baltimore City foster children in the federal *L.J.* case discussed below and have served as class counsel since 1988. A modified consent decree currently in effect prohibits housing foster children in unlicensed facilities like hospitals. In addition, I am co-counsel with Disability Rights Maryland in another federal class action, *T.G*, which seeks to end hospital overstays of foster children outside of Baltimore City. *T.G.* also is pending in the U.S. District Court for the District of Maryland. Overall, I have been involved in foster care reform at the federal, state, and local levels since 1979.

I. The Placement Crisis in Maryland's Foster-Care System.

A grave, unrelenting foster-care placement shortage has existed in Maryland for at least the last five to six years, maybe longer. Hundreds of foster children have languished in hospital emergency departments and psychiatric wings of acute care hospitals, or in psychiatric hospitals, without *any* medical necessity. These hospital "overstays" typically last for weeks or months, but have even lasted for more than a year in a few circumstances. They are illegal and unconscionable. Other children languish in these same settings because they cannot return home, as their families have abandoned them or need services to be able to care for them, and must wait in hospitals until the Department of Human Services (DHS) or the Department of Health (MDH) finds a foster-care bed for placement.

DHS's own regulations make clear that hospitals are not valid "placements." *See, e.g.*, COMAR 07.02.11.06.B(5)(g) (affirming that, for children with disabilities seeking voluntary placement, psychiatric hospitals are *never* a recognized placement, let alone an *appropriate* and *least restrictive* placement). Hospitals are licensed to provide acute medical care, not provide foster-care or residential child-care services and therefore may not be utilized for those purposes.

See COMAR 07.02.11.11.I ("Any residential child care facility used by the local department shall meet the requirements for licensure for the facilities established in COMAR 14.31.05."). And emergency departments are limited by statute to stays lasting a maximum of only 30 hours. Md. Code Ann. Health-Gen. § 10-624(b)(4).

Housing foster children in psychiatric hospitals or emergency departments illegally for weeks and months without *any* medical need is a Gothic, Cuckoo's Nest nightmare that should have halted a century ago or more. For abused, neglected, and maltreated foster children, it is deplorable, an absolute tragedy that has persisted for years with no end in sight.

Languishing in an E.R. or psychiatric ward without medical necessity harms children: their schooling is interrupted (it often takes weeks or months before small amounts of tutoring are arranged); they rarely are exposed to fresh air; they have no or scant opportunity for recreation; and they have almost no socializing opportunities. They spend almost all of their time confined to a bed or sit in a chair. Visits from relatives or friends are infrequent at best and usually are rare. Instead of treatment, children sometimes receive psychotropic medication as a means of keeping them quiet and trouble-free. Whatever progress might be made initially from the hospitalization usually vanishes and is replaced by regression and decline resulting from the children's isolation. Indeed, extensive studies and voluminous academic literature confirm that prolonged hospitalization damages children, as their developmental progress is halted and impaired.

Time and time again, the DHS and MDH Secretaries have testified before various legislative committees of the General Assembly and vowed to fix the problem soon. Year after year, the promised fixes don't arrive or don't work as promised. Just last year, at a budget hearing, the DHS Secretary testified, "I will fix it." Yet the Office of Public Defender reported recently that it represents 10 children in hospital overstays. The Baltimore City Department of Social Services reported yesterday that two foster children had to stay overnight in one of its offices. Last Friday (February 10, 2025), the most recent data available, it reported six foster children in hospital overstays.

The Secretaries insist that no placement crisis exists and that plenty of beds are available, and they blame the private providers for being too picky and non-responsive. I strongly disagree. Maryland does not have the array of services and creative placements and systems reform that some other jurisdictions have developed to address similar crises in their states. Wraparound services, for instance, were supposed to be implemented over a decade ago, but we are still waiting for implementation, even though they have been effective elsewhere in preventing hospitalization. Medicaid reforms have been promised but are still not at hand. Rate reform has only just commenced and is still underway. In FY 2024, the State lost a net of at least 50 and perhaps up to 120 beds. We have pointed out approaches used by other jurisdictions facing similar problems but have not, to date, persuaded DHS and MDH to pursue these.

The problem is not, as the State often portrays it, mostly older children with severe behavioral health disorders that no facility will take. Most children do get placed in the community, eventually. Medically fragile infants have had to stay in hospitals without medical necessity due to the lack of foster homes. The Committee should understand that most of these children *do not require placements in expensive residential treatment centers* ("RTCs"). Most foster children in hospital overstays do not go to RTCs or to long-term hospital placements. Instead, more than half get placed in the community: with parents, relatives, foster homes, or group homes. The Baltimore City DSS numbers are startling:

- From Jan. 1, 2021 to June 7, 2023, only 7.5% of overstays (18 of 239 dispositions) concluded with placements in RTCs. 53% ended with community placements.[1] 20% of the children returned to their original placements, begging the question why the overstays were needed in the first place.[2]

- Over a third of the 245 reported Baltimore City overstays during this period were 13 years old or younger. Some were infants who waited in hospitals for a foster-home placement.[3] *Id.* at 14.

- Since then, an even higher proportion of community placements has been used to end overstays. From June 8, 2023 to May 31, 2024, 88% of the Baltimore City DSS hospital overstays were resolved with community placements, with 29% to relatives and 21% to foster homes), not RTCs or other hospital settings.[4]

- From July 1, 2023 to June 1, 2024, the mean length of Baltimore City DSS hospital overstays was 32 days.[5]

Just recently, we learned of Baltimore City youth who was spending months in Northwest Hospital's emergency department in overstay, waiting first for an RTC, then for another hospital bed. This 14-year-old boy had previously been placed with an aunt, suffered horrific physical abuse from his father and nearly died, and had significant deficits as a result. He recently was assaulted by another patient unprovoked, while sitting in a chair quietly outside of his room, resulting in a swollen eye observed by his caseworker the next day, and the police was called. We wrote to the DHS Secretary about this as soon as we heard of it, and, within a week, he was moved

[1] *L.J. v. Lopez*, No. 1:84-cv-04409-SAG, ECF No. 682-1 at 13 (D. Md. Dec. 19, 2023).
[2] *Id.*
[3] Id. at 14.
[4] *L.J.*, *supra*, ECF No. 692 at 8 (June 10, 2024).
[5] *Id.*

to a group home, where he should have been all along. This is a perfect example of the deplorable state of Maryland's placement and service array.

Perhaps if this were a new problem, DHS and MDH should be given more time to try to solve it. But they have had *years* to do so and have failed. Bills have been introduced, hearings have been held, letters were written, many meetings have occurred, and massive litigation launched. Yet the State has not budged in its nothing-wrong-here refusal to acknowledge that a placement crisis exists and develop the placement and service array that would fix it. Respectfully, enough is enough. The General Assembly must act, or it, too, will be complicit.

Hospital overstays are a form of maltreatment. By refusing to pick up the children from hospitals, Defendants abandon them, just as surely as parents do when they do not provide reasonable care for their children. Indeed, if parents leave their children in hospitals out of desperation because they cannot are unable to care for the children in the home without more services, they may face CINA petitions charging them with neglect or abandonment. *See, e.g., In re: A.C.*, No. 1467, Sept. Term 2021, 2022 WL 1566998 (Md. Ct. Spec. App. May 18, 2022). When DSS refuses to pick up a foster child from the hospital when called by a hospital social worker because DSS lacks a placement and services to care for the child, the same neglect is occurring. It is no less a form of maltreatment when the State does it.

II. S.B. 696, If Amended, Is a Good First Step to Address the Placement Crisis.

S.B. 696 includes three important measures for addressing the placement crisis that causes hospital overstays.

First, it creates a "coordinator" position in the Governor's Office for Children to advocate on behalf of the children. This is a crucial measure, especially for the children who are stuck in hospitals waiting for foster care placements to open. Those children do not have advocates and are virtually invisible to the outside world. S.B. 696 is the first bill in years that tries to fix their horrible situation. Even just collecting data about these children will be invaluable.

Second, it requires the coordinator to assess and address shortcomings in state services and placements that contribute to or principally cause hospital overstays.

Third, it requires MDH to work to ensure that the children are placed in the least restrictive setting possible. For some children, such as children with autism, MDH's role is crucial in designing and obtaining appropriate placements and services. Similarly, the lack of intensive home-bases services such as wraparound ultimately is a problem that MDH can fix more readily than can DHS.

Each of these makes S.B. 696 a worthwhile bill that warrants a favorable report. But, as discussed in the next section, it has one feature that will cause more harm than good and therefore should be stricken.

III. S.B. 696 Needs to Be Amended in Order to Help the Children Appropriately.

In Attachment 1, I propose several amendments for strengthening S.B. 696. One of these (funding for RICA beds) is sufficiently vital that I cannot support the bill with that provision.

A. The provisions for expanded RICA funding should be stricken. The bill's only concrete mechanism for addressing the supply inadequacy is increased funding for the two state-operated "RICA" RTC facilities (one in Rockville, one in Baltimore). This is a terrible idea. As discussed above, the children in hospital overstays typically do not go to RTCs. Increasing the number of RICA beds will not solve the problem. But the proposal actually is worse than that: it will cause harm.

In my near four decades of work with the Maryland child welfare system, it has been an almost universal fact that foster children *loathe* the RICAs, far more than the RTCs run by private-sector providers. For reasons why, I urge the Committee members to review an article from Silver Chips, the award-winning student newspaper of Montgomery Blair H.S. in Silver Spring, titled, "*They Call It a Hospital, but It Basically Was a Prison*" (Jan. 27, 2021). Among other things the article interviewed two Blair students who had resided at the RICAs: their comments describing the RICAs as prison-like facilities matches what I have heard for decades. Of all the possible solutions to the overstay issue, expanding the RICAs is the very worst one possible. I cannot support a measure that will do a lot of harm to the children and little good.

Indeed, as discussed above, more RTCs is not the answer. The children can and are placed into the community, and so community-based solutions are needed. Putting the children in RTCs will merely kick the placement shortage down the road.

Diverse experts have made this clear. The Department of Legislative Services has issued a report on the issue, repeating the findings of the Governor's Office for Children, that RTCs are not appropriate answers for the children in overstays, concluding "that "RTCs and other high-level residential programs … currently do not offer an adequate level of *services on an ongoing basis to fully address the needs of youth who are at most risk of experiencing a hospital overstay or an out-of-state placement*."[6] Similarly, researchers at the Maryland School of Social Work conducted a "needs assessment" of placements for the Baltimore City DSS and DHS, and it concluded that *no* new RTC beds were needed, that community placements and services were needed instead, and

[6] Dep't of Legislative Servs., Dep't of Hum. Servs. Fiscal 2025 Budget Overview at 33 (Jan. 2024) (emphasis added).

that some children in RTCs should be stepped down.[7] Finally, the U.S. Senate Finance Committee has issued a scathing report about out-of-state RTCs and concluding that extremely structured congregate care like RTCs simply does not work.[8] Many of the findings in the Committee's report probably could be made about Maryland's RICAs.

In short, expanding RICAs is the worst way possible to address the placement shortage. I urge the Committee to amend the bill to remove the pertinent provisions.

B. The Committee should strike the provision authorizing hospitals to seek placements of children in and out-of-state. Hospitals are not "placement providers" as that term is understood in Maryland. Placing children is the responsibility of DHS and MDH, not hospitals. Giving quasi-placement authority to hospitals, especially when hospitals have strong incentives to secure the removal of children in overstays, will create chaos and blur boundaries in a negative way.

C. The Committee should add an amendment to require DHS and MDH to work with private placement providers, Disability Rights Maryland, attorneys for the children and other advocates to come up with a concrete assessment of needs and plans to resolve those needs. To date, both Departments have sternly resisted any such effort. Without this level of collaboration, the problem will never be solved. Planning is key, and without legislative impetus, it simply will never occur. The last six years of inaction are proof positive of that.

D. The Committee should add an amendment to require discharge planning to commence immediately upon a child's admission to a hospital, and not to wait until the hospital calls for the child's removal. MDH regulations already require this for certain hospitals as a result of the Lisa L. settlement some 30 years ago. But those hospitals have mostly closed or no longer serve children, so the regulations are largely vestigial. The requirement should be restored as an active legally binding requirement for MDH, DHS, and the hospitals.

All of these amendments are set forth in Attachment 1, as well as other proposed technical amendments that improve upon the bill's language.

I greatly appreciate the Committee's consideration of these issues.

[7] Terry Shaw, et al., Univ. of Md. Sch. of Soc. Work, "Baltimore City Placement Review," May 2022 at 20.
[8] U.S. Sen. Finance Comm., "Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities",

Respectfully submitted,

/s/ Mitchell Y. Mirviss

Proposed Amendments to SB 696 (2025).pdf
Uploaded by: Mitchell Mirviss
Position: FWA

PROPOSED AMENDMENTS TO SB 696 (2025) AND HB 962 (2025)

Page 3, Line 5	Insert (“A”) between “WHO” and “REMAINS
Page 3, Line 7	At end of sentence, change period to a comma and add “(B) OR IS RELEASED BY AN ADMINISTRATIVE LAW JUDGE.”
Page 3, Line 9	Delete “(A”) at the beginning of the paragraph.
Page 3, Line 12	At end of sentence, before period, add “, AND AS SOON AS POSSIBLE”
Page 3, Lines 13-16	Delete entire paragraph: ~~“(B) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, TO ENSURE THAT 14 A PEDIATRIC HOSPITAL OVERSTAY PATIENT IS TREATED IN THE LEAST RESTRICTIVE 15 SETTING, A HOSPITAL MAY CONCURRENTLY EXPLORE IN–STATE AND 16 OUT–OF–STATE PLACEMENT OPTIONS.~~”
Page 3, Lines 17-28	Delete entire proposed new Section 19-390 of the Health-General Article: ~~19–390.~~ ~~(A) (1) FOR FISCAL YEAR 2026, THE GOVERNOR MAY INCLUDE IN THE 19 ANNUAL BUDGET BILL AN APPROPRIATION SUFFICIENT TO FILL ALL POSITIONS 20 AUTHORIZED FOR A REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS IN THE STATE. (2) FOR FISCAL YEAR 2027 AND EACH FISCAL YEAR THEREAFTER, THE GOVERNOR SHALL INCLUDE IN THE ANNUAL BUDGET BILL AN APPROPRIATION SUFFICIENT TO FILL ALL POSITIONS AUTHORIZED FOR A REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS IN THE STATE. (B) THE GOVERNOR MAY USE FUNDS DESIGNATED FOR THE ADOLESCENT HOSPITAL OVERSTAY PROGRAM FOR THE PURPOSES IDENTIFIED IN SUBSECTION (A) OF THIS SECTION.~~
Page 4, Line 23	Replace “BEST INTEREST OF A PEDIATRIC OVERSTAY PATIENT” with “BEST INTEREST OF EACH PEDIATRIC OVERSTAY PATIENT”
Page 4, Line 26	At end of sentence, before the period, add: “,TO FIND AND SECURE IMMEDIATE APPROPRIATE PLACEMENT AND SUPPORTIVE SERVICES FOR EACH PEDIATRIC OVERSTAY PATIENT, INCLUDING ALL EDUCATIONAL AND HEALTH SERVICES AND PROGRAMS THAT THE PATIENT NEEDS”
Page 5, Line 1	Insert “ALL” between “RELATED TO” and “PEDIATRIC OVERSTAY PATIENTS”

Page 5, Line 5 Insert "AND CHILD WELFARE" between "HEALTH" and "INFORMATION"

Page 5, Line 23 Insert between "HEALTH DIAGNOSIS;" and "AND" new paragraphs (VI), (VII), and (VIII):

"(VI) THE CHILD'S AGE, RACE, ETHNICITY, SEX, GENDER, DISABILITY STATUS, COUNTY OF RESIDENCE, AND LOCATION OF LOCAL DSS SERVING THE CHILD;

(VII) PROTECTIVE SERVICES STATUS AND HISTORY, IF ANY;

(VIII) DURATION OF HOSPITALIZATION AND HOSPITAL OVERSTAY STATUS;"

Page 5, Line 24 Change "(VI)" to "(IX)"

Page 5, Line 25 Insert new Paragraph (E):

"(E) WITHIN THREE MONTHS OF THE EFFECTIVE DATE OF THIS ACT, THE COORDINATOR SHALL COMPLETE AN ASSESSMENT OF THE NUMBER, TYPES, AND COST OF THE ADDITIONAL BEDS AND THE SUPPORTIVE SERVICES NEEDED TO PLACE ALL CHILDREN IN PEDIATRIC OVERSTAYS IN THE LEAST RESTRICTIVE PLACEMENT, AS SOON AS POSSIBLE. THE COORDINATOR SHALL MAKE THIS ASSESSMENT BY WORKING WITH REPRESENTATIVES OF (i) THE MARYLAND DEPARTMENTS OF HEALTH AND HUMAN SERVICES, AS WELL AS REPRESENTATIVES OF (ii) PRIVATE PLACEMENT PROVIDERS OF FOSTER CARE SERVICES AND BEHAVIORAL HEALTH SERVICES IN MARYLAND; DISABILTY RIGHTS MARYLAND; THE OFFICE OF THE PUBLIC DEFENDER; AND LAWYERS WHO REPRESENT FOSTER CHILDREN IN PEDIATRIC OVERSTAYS."

Page 5, Line 25 Change "(E)" to "(F)":

Page 6, Line 1 Add new Section (G):

"(G) TO HELP PREVENT PEDIATRIC HOSPITAL OVERSTAYS FROM OCCURRING, WHENEVER A CHILD OR YOUTH UNDER AGE 22 IS HOSPITALIZED AND LACKS A PLACEMENT FOR WHEN THE CHILD OR YOUTH IS READY FOR DISCHARGE, THE DEPARTMENTS OF HEALTH AND HUMAN SERVICES SHALL COMMENCE DISCHARGE PLANNING WITH THE HOSPITAL TO FIND

PLACEMENTS AND SUPPORTIVE SERVICES IN THE LEAST RESTRICTIVE SETTINGS THAT WILL BE AVAILABLE WHEN THE CHILD IS READY FOR DISCHARGE. SUCH DISCHARGE PLANNING SHALL, AT A MINIMUM, MEET THE CRITERIA OF CODE OF MARYLAND REGULATIONS SECTIONS 14.31.03.03 through 14.31.03.05."

SB696_FWA_DHS.pdf
Uploaded by: Rachel Sledge Government Affairs
Position: FWA

Maryland
DEPARTMENT OF HUMAN SERVICES
Wes Moore, Governor · Aruna Miller, Lt. Governor · Rafael López, Secretary

February 18, 2025

The Honorable Pamela Beidle, Chair
Senate Finance Committee
3 East Miller Senate Office Building
11 Bladen St.
Annapolis, Maryland 21401

RE: TESTIMONY ON SB0696 - PUBLIC HEALTH - PEDIATRIC HOSPITAL OVERSTAY PATIENTS - POSITION: FAVORABLE WITH AMENDMENTS

Dear Chair Beidle and Members of the Finance Committee:

The Maryland Department of Human Services (DHS) thanks the Committee for the opportunity to provide favorable testimony with amendments for Senate Bill 696 (SB 696).

With offices in every one of Maryland's jurisdictions, DHS provides preventative and supportive services, economic assistance, and meaningful connections to employment development and career opportunities to assist Marylanders in reaching their full potential. Our Social Services Administration implements the child welfare program and the children we serve are affected by SB 696. A portion of the children who experience hospital overstays beyond medical necessity are simultaneously involved with the child welfare system.

Based on recent DHS reporting, in federal Fiscal Year 2024, 102 children in the care and custody of Local Departments of Social Services experienced a hospital overstay. DHS agrees a hospital overstay is not acceptable for any child, but especially for those with complex medical and/or behavioral health needs. Over the past year, we developed new kinship care resources, regulations, and implemented an incentivized compensation structure for residential care providers. Our systemic changes are designed ensuring all children have their needs met in the most appropriate and least restrictive setting. In addition, DHS is finalizing a new policy providing guidance to Local Departments of Social Services (LDSS) for youth in hospitals. The goal is to facilitate a comprehensive multidisciplinary team approach to medical discharge planning and well-being. The policy focuses on collaboration among the Social Services Administration's (SSA) placement unit, the LDSS, and the hospital clinical team. While youth are in a hospital setting the LDSS will work to identify the most appropriate and least restrictive setting, and oversee youth safety and well-being.

DHS agrees with the intent of the bill to minimize and reduce hospital overstays. We recommend two amendments to help clarify the bill and improve implementation and coordination with the Maryland Department of Health (MDH).

First, we propose the Committee clarify the scope of children experiencing a hospital overstay who are included under the bill terms. We propose changing the text from "under the age of 22" to "through the age of 21." DHS does not have care and custody of young people over the age of 18 unless they continue in care to age 21 or emancipate and elect to return before age 21.

Next, the recommended amendment below would define a hospital overstay as beyond 48 hours after clearance for discharge, which aligns with the timeframe used in COMAR 10.21.31.04 regarding the Maryland Department of Health's Maryland Mental Health and Substance Use Disorder Registry and Referral System.

> 19–388. IN THIS PART, "PEDIATRIC HOSPITAL OVERSTAY PATIENT" MEANS A PATIENT ~~UNDER THE AGE OF 22~~ **THROUGH THE AGE OF 21** YEARS WHO REMAINS IN AN INPATIENT UNIT OR EMERGENCY DEPARTMENT OF A HOSPITAL FOR MORE THAN ~~24~~ **48** HOURS AFTER BEING MEDICALLY CLEARED FOR DISCHARGE OR TRANSFER.

Finally, we request an amendment to clarify that DHS is only responsible for the youth in our care and custody, and is not responsible for other children or youth.

> 19–389. (A) THE DEPARTMENT~~, IN COORDINATION WITH THE DEPARTMENT OF HUMAN SERVICES,~~ SHALL ENSURE THAT A PEDIATRIC HOSPITAL OVERSTAY PATIENT IS TRANSFERRED TO AND TREATED IN THE LEAST RESTRICTIVE SETTING POSSIBLE. **THE DEPARTMENT SHALL COORDINATE WITH THE DEPARTMENT OF HUMAN SERVICES FOR THE TRANSFER OF PEDIATRIC HOSPITAL OVERSTAY PATIENTS IN THE CARE AND CUSTODY OF THE DEPARTMENT OF HUMAN SERVICES.**

We appreciate the opportunity to offer favorable testimony with amendments to the Committee for consideration during your deliberations. If you require additional information, please contact Rachel Sledge, Director of Government Affairs, at rachel.sledge@maryland.gov.

In service,

Carnitra White
Principal Deputy Secretary

SB696_MDH_FWA
Uploaded by: Sarah Case-Herron
Position: FWA

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 18, 2025

Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

RE: Testimony on Senate Bill (SB) 696 - Public Health - Pediatric Hospital Overstay Patients

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of support with amendments for Senate Bill (SB) 696 - Public Health - Pediatric Hospital Overstay Patients. This bill seeks to specify that the Maryland Mental Health and Substance Use Disorder Registry and Referral System include both private and State providers, that the state annual budget include an appropriation for all authorized positions in Maryland's Regional Institutes for Children and Adolescents (RICAs), and permits funds designated for the Department's Adolescent Hospital Overstay Program to be used for this purpose. This bill also proposes to create a new position in the Governor's Office for Children (GOC), the Pediatric Hospital Overstay Coordinator, to oversee related efforts.

The Department's current Mental Health and Substance Use Disorder Registry and Referral System, the Behavioral Health Hospital Coordination Dashboard, aims to improve the process and urgency of connecting children and adults with behavioral health inpatient psychiatric beds around the state. The Department is in the process of procuring a software vendor to establish a new statewide electronic system that will replace the current dashboard, create a comprehensive provider directory for inpatient, crisis, and outpatient services and streamline the referral process across providers.

In addition to these efforts, the Department funds the 211 Behavioral Health Care Coordination program, which supports and connects hospital staff, discharge planners, and social workers in emergency departments to community-based behavioral health resources for patients. In order for this electronic Bed Registry and Referral System to be successful, we recommend requiring hospitals and all inpatient, outpatient, and crisis behavioral health providers to provide Directory information and update service availability in real-time. It is critical that all state overstay efforts outlined in the bill are connected with this Bed Registry and Referral System, which will be administered by the Department.

Interagency collaboration to address pediatric overstays is critical to the wellbeing of Maryland's youth with serious emotional disturbances. The Department has staff who actively collaborate with other state agencies - including the Department of Human Services (DHS) - to weekly track and provide technical assistance to providers working with complex and overstay pediatric and adult patients in inpatient and emergency room settings. The group also uses the forum to collaborate on strategies to address the needs of these youth, including group discussion on resources to address pediatric overstays.

The bill proposes that the Department, in coordination with DHS, "ensure" that a pediatric hospital overstay patient is transferred to and treated in the least restrictive setting possible. While the Department always does their best to help identify the least restrictive setting possible, ultimately, hospitals and facilities determine which patients to admit. Given the Department's current efforts to track pediatric overstays, we believe that operational and financial resources should focus on expanding and enhancing programming to meet the needs of youth outside of hospitals. The Department has proposed amendments to track the current work underway.

Moreover, the Department has significant concerns about ensuring placements as the Department is not a placement agency nor has the authority to ensure admittance to a facility or program. The Department has no legal authority for the transfer and treatment of youth. The Department will defer to the Office of the Attorney General but there is some concern with this language.

While the legislation calls for a rate study, the Department would like to highlight that HB1329/SB967—Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017 (Chs. 571 and 572 of the Acts of 2017) requires the Department to conduct cost-driven, rate-setting studies to set community-based behavioral health provider rates and implement a payment system based on study findings. The Department has selected a vendor and has begun the process to develop next steps for this initiative that will cover parts of the study outlined in this legislation.

The Department also notes that due to federal rules related to upper payment limits, meaning that Medicaid may not pay providers more than what Medicare would pay for the same service, RTCs are unable to be reimbursed on a prospective payment system. Therefore, because of federal rules, a study to assess prospective payment systems for RTCs is not possible to implement. The Department notes that it does have regulations COMAR 10.09.29.07 to support the treatment of children with particularly acute illnesses as needed to ensure RTC providers are adequately reimbursed for the services they provide.

Should this legislation be implemented, the Department anticipates a significant investment in state general funds with a total approximate cost of $5,678,682. This is reflective of approximately 2 FTE across four (4) positions to support day-to-day program operations with a cost of $193,986**.** This legislation will also require the Department to review reimbursement rates paid to residential treatment centers and respite care facilities and study the implementation of a prospective payment model with an anticipated cost of $101,111. Moreover, this legislation calls for increased staffing of the RICAs, with an estimated cost of $5,383,585 for the fiscal year 2026.

The Department recognizes that there is a need for a behavioral health continuum of care for youth and families that is made readily available; however this legislation, as currently written, will not solve the current overstay concerns. The Department continues to participate in conversation with bill sponsors and stakeholders and suggests the following amendments. If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

AMENDMENTS TO SENATE BILL 696
(First Reading File Bill)

On page 2, insert after line 29 "**(5) PROVIDERS OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING INPATIENT, CRISIS, AND OUTPATIENT SERVICES, SHALL PROVIDE DATA IN REAL TIME TO EFFECTUATE THE REGISTRY AND REFERRAL SYSTEM.**".

On page 3, in line 5, strike "UNDER THE AGE OF 22 YEARS" and substitute "**21 YEARS OR YOUNGER**".

On page 3, insert after line 7 "**COORDINATOR" MEANS THE PEDIATRIC HOSPITAL OVERSTAY COORDINATOR WITHIN THE MARYLAND DEPARTMENT OF HEALTH AND DEPARTMENT OF HUMAN SERVICES**".

On page 3, in line 6, strike "24" and substitute "48"; and in the same line, strike starting with "BEING" through "TRANSFER" in line 7 and substitute "**BEING STABILIZED UNDER THE PROVISIONS OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT AND READY FOR APPROPRIATE COMMUNITY PLACEMENT. IF THE YOUTH EXCEEDS 48 HOURS IN THE EMERGENCY DEPARTMENT AND THE HOSPITAL OR BED REGISTRY SHOWS AVAILABILITY FOR AN INPATIENT BED THE HOSPITAL WILL SEEK THE APPROPRIATE TRANSFER TO MAINTAIN CLINICAL STABILITY OF THE YOUTH.**".

On page 3, line 12, before "POSSIBLE" insert "**WHEN CLINICALLY INDICATED AND/OR WHEN**".

On page 3, line 18, strike starting with "(A)(1)" through "Committee." on page 6, line 14 and substitute, "**(A) THERE IS A PEDIATRIC HOSPITAL OVERSTAY COORDINATOR WITHIN THE DEPARTMENT AND DEPARTMENT OF HUMAN SERVICES.**

(B) THE COORDINATORS SHALL ACT IN THE BEST INTEREST OF A PEDIATRIC HOSPITAL OVERSTAY PATIENT BY COORDINATING BETWEEN HOSPITALS, RELEVANT STATE AGENCIES AND PROGRAMS, AND PROVIDERS OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

(C) THE COORDINATORS SHALL:

(1) ADVOCATE ON BEHALF OF PEDIATRIC HOSPITAL OVERSTAY PATIENTS WHILE MAINTAINING APPROPRIATE PATIENT CONFIDENTIALITY;
(2) REVIEW POLICIES AND PROCEDURES OF RELEVANT STATE AGENCIES AND MAKE RECOMMENDATIONS FOR NECESSARY CHANGES TO THE POLICIES AND PROCEDURES TO BETTER SERVE PEDIATRIC OVERSTAY PATIENTS;
(3) MAINTAIN DATA ON EACH PEDIATRIC HOSPITAL OVERSTAY PATIENT, INCLUDING:

(I) PATIENT'S LENGTH OF STAY;

(II) THE RESPONSIBLE STATE AGENCY, IF APPLICABLE;

(III) SERVICES NEEDED;

(IV) PLACEMENT OPTIONS BEING SOUGHT BY THE PATIENT;

(V) INFORMATION REGARDING PREVIOUS HOSPITAL ADMISSIONS FOR BEHAVIORAL HEALTH DIAGNOSIS; AND

(VI) ANY OTHER RELATED DATA, AND

(4) **REPORT ON THIS DATA COLLECTED TO THE SECRETARY.**".

SB696_MARFY__FWA.pdf
Uploaded by: Therese Hessler
Position: FWA

Maryland Association of
Resources for Families & Youth

February 18, 2025

Senate Bill 696 - Public Health - Pediatric Hospital Overstay Patients

Senate Finance Committee

Position: SUPPORT WITH AMENDMENTS

The Maryland Association of Resources for Families and Youth (MARFY) appreciates the opportunity to submit written testimony in support of Senate Bill 696, with amendments. MARFY is an association of private child-caring organizations dedicated to providing foster care, treatment, and independent living programs to Maryland's most vulnerable children—those in out-of-home placements due to abuse, neglect, severe mental health conditions, or medical needs. Our members serve children in group homes, treatment foster care programs, and independent living arrangements, working to ensure their safety, stability, and well-being.

While we recognize and commend the intent of SB 696 to address the issue of pediatric hospital overstays, we strongly believe that this legislation must be amended to encompass a broader scope that includes all unlicensed settings where youth may be placed. The current framework of the bill primarily focuses on hospital overstays, yet we know that misplacement and lack of appropriate care extend far beyond hospital settings. If we solely address hospital overstays, we are failing to create a long-term, sustainable solution that fully meets the needs of Maryland's youth. This legislation presents a great opportunity to save lives and move forward in a cohesive effort to improve child welfare in our state.

We urge the committee to adopt the amendments that follow our written testimony which address the broader issue of misplacement in all unlicensed settings. Without these amendments, the bill will fall short of providing a comprehensive solution that truly safeguards the well-being of Maryland's children – and unfortunately, it would be remiss to support legislation that does not address these concerns.

We appreciate your consideration of these critical amendments and look forward to working with the bill sponsor and the committee to strengthen SB 696 to meet the full scope of youth placement challenges in Maryland.

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PROPOSED SB0696 AMENDED VERSION (AMENDMENTS NOTED IN BLUE):

FOR the purpose of specifying that the scope of the Maryland Mental Health and Substance Use Disorder Registry and Referral System includes both private and State inpatient and outpatient mental health and substance use services; requiring the Maryland Department of Health, in coordination with the Department of Human Services, to ensure pediatric hospital overstay patients are placed in the least restrictive setting possible; ~~authorizing a hospital to concurrently explore in–State and out–of–state placements for pediatric hospital overstay patients;~~ establishing the Pediatric Hospital Overstay and Unlicensed Placement Coordinator within the Governor's Office for Children; requiring the Maryland Department of Health to conduct a certain study and review of residential treatment center and respite facility rates; requires the DHS and MDH to conduct a data-driven study of the characteristics and needs of children and youth in ER and hospital overstays, as well as those in unlicensed placements and the contracted beds to serve the children with those needs; develop a comprehensive plan to end the practice of ER and hospital overstays with a report due to the Legislature by 12/25; and generally relating to pediatric hospital overstay patients and children and youth in DHS custody in unlicensed settings.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 7.5–802(a) and (d)
Annotated Code of Maryland
(2023 Replacement Volume and 2024 Supplement)

BY adding to
Article – Health – General
Section 19–388 through 19–390 to be under the new part "Part XII. Pediatric Overstay AND UNLICENSED SETTINGS"
PART XII. PEDIATRIC OVERSTAY AND UNLICENSED SETTINGS.
19–388.
BY repealing and reenacting, with amendments,
Article – State Government
Section 9–2801
Annotated Code of Maryland

(2021 Replacement Volume and 2024 Supplement)
BY adding to
Article – State Government
Section 9–2806

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Annotated Code of Maryland
(2021 Replacement Volume and 2024 Supplement)
SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

7.5–802.

(a) (1) There is a Maryland Mental Health and Substance Use Disorder Registry and Referral System in the Department.

(2) The purpose of the Registry and Referral System is to provide a statewide system through which health care providers can identify and access available **PRIVATE AND STATE** inpatient and outpatient mental health and substance use services for patients in a seamless manner.

(3) Subject to the availability of funds, the Department shall develop and implement the Registry and Referral System, in collaboration with the State–designated Health Information Exchange.

(4) The Registry and Referral System shall include:

(i) A searchable inventory of any **PRIVATE OR STATE** provider of mental health and substance use disorder services, including inpatient, crisis, and outpatient services;

(ii) The capability to allow a provider of mental health and substance use disorder services to update registry information including the real–time availability of services; and

(iii) An electronic referral system that is available to any health care provider in the State to facilitate electronic referrals to mental health and substance use disorder providers.

(d) Each **PRIVATE AND STATE** hospital shall ensure the availability of staff to identify appropriate and available services for patients in the hospital who are in need of mental health or substance use disorder services and to assist the patient in accessing the services.

19–386. RESERVED.

19–387. RESERVED.

PART XII. PEDIATRIC OVERSTAY AND UNLICENSED SETTINGS.

19–388.

IN THIS PART, "PEDIATRIC HOSPITAL OVERSTAY PATIENT" MEANS A PATIENT UNDER THE AGE OF ~~22~~ 21 YEARS WHO REMAINS IN AN INPATIENT UNIT OR EMERGENCY DEPARTMENT OF A HOSPITAL FOR MORE THAN 24 HOURS AFTER BEING MEDICALLY CLEARED FOR DISCHARGE OR TRANSFER.

"CHILD IN UNLICENSED SETTING" MEANS A CHILD IN OUT OF HOME PLACEMENT RESIDING IN HOTELS, OFFICE BUILDINGS,

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SHELTERS, OR OTHER UNLICENSED SETTINGS EXCLUDING YOUTH RECEIVING SILA STIPEND OR THOSE WITH KIN AWAITING APPROVAL.

19–389.

(A) THE DEPARTMENT, IN COORDINATION WITH THE DEPARTMENT OF HUMAN SERVICES, SHALL ENSURE THAT A PEDIATRIC HOSPITAL OVERSTAY PATIENT AND CHILD IN UNLICENSED SETTINGS WITH THE EXCEPTION OF KIN OR SILA RECIPIENTS IS TRANSFERRED TO AND TREATED IN THE LEAST RESTRICTIVE SETTING POSSIBLE.

(B) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, TO ENSURE THAT A PEDIATRIC HOSPITAL OVERSTAY PATIENT IS TREATED IN THE LEAST RESTRICTIVE SETTING, ~~A HOSPITAL~~ DHS MAY CONCURRENTLY EXPLORE IN–STATE AND 15 OUT–OF–STATE PLACEMENT OPTIONS.

19–390.

(A) (1) FOR FISCAL YEAR 2026, THE GOVERNOR MAY INCLUDE IN THE ANNUAL BUDGET BILL AN APPROPRIATION SUFFICIENT TO FILL ALL POSITIONS AUTHORIZED FOR A REGIONAL INSTITUTE FOR CHILDREN AND ADOLESCENTS IN THE STATE THAT IS MANDATED TO ACCEPT CHILDREN FROM ALL JURISDICTIONS.

(2) FOR FISCAL YEAR 2027 AND EACH FISCAL YEAR THEREAFTER, 22 THE GOVERNOR SHALL INCLUDE IN THE ANNUAL BUDGET BILL AN APPROPRIATION 23 SUFFICIENT TO FILL ALL POSITIONS AUTHORIZED FOR A REGIONAL INSTITUTE FOR 24 CHILDREN AND ADOLESCENTS IN THE STATE.

(B) ~~THE GOVERNOR MAY USE FUNDS DESIGNATED FOR THE ADOLESCENT HOSPITAL OVERSTAY PROGRAM~~ THE DHS MAY USE FUNDS OTHERWISE DESIGNATED TO FUND UNLICENSED SETTINGS TO STRENGTHEN SERVICES AND STAFFING FOR THE PURPOSES IDENTIFIED IN SUBSECTION (A) OF THIS SECTION.

9-2801

a) In this subtitle the following words have the meanings indicated.

(B) "COORDINATOR" MEANS THE PEDIATRIC HOSPITAL OVERSTAY AND UNLICENSED SETTINGS COORDINATOR WITHIN THE GOVERNOR'S OFFICE FOR CHILDREN.

[(b)**]** **(C)** "Eligible neighborhood" means a neighborhood that includes census tracts with more than 30% of children living in poverty and is served by, as defined by the 5 Office, a community school with a concentration of poverty level, as defined in § 5–223 of 6 the Education Article, of:

(1) in fiscal year 2025 and 2026, at least 80%;

(2) in fiscal year 2027 through fiscal year 2029, at least 75%;

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(3) in fiscal year 2030, at least 60%; and
(4) in fiscal year 2031, and each fiscal year thereafter, at least 55%.
[(c)] (D) "Fund" means the ENOUGH Grant Fund.
[(d)] (E) "Office" means the Governor's Office for Children.
(F) "PEDIATRIC HOSPITAL OVERSTAY PATIENT" AND "CHILD IN UNLICENSED SETTINGS" HAS THE MEANING STATED IN § 19–388 OF THE HEALTH – GENERAL ARTICLE.
[(e)] (G) "Program" means the Engaging Neighborhoods, Organizations, Unions, 16 Governments, and Households (ENOUGH) Grant Program.
[(f)] (H) "Special Secretary" means the Special Secretary of the Governor's 18 Office for Children.
9–2806.
(A) THERE IS A PEDIATRIC HOSPITAL OVERSTAY COORDINATOR WITHIN THE OFFICE.
(B) THE COORDINATOR SHALL ACT IN THE BEST INTEREST OF A PEDIATRIC HOSPITAL OVERSTAY PATIENT BY COORDINATING BETWEEN RELEVANT STATE AGENCIES AND PROGRAMS, INCLUDING PUBLIC BEHAVIORAL HEALTH CARE AND PROGRAMS FOR CHILDREN WITH AUTISM AND OTHER DEVELOPMENTAL DISORDERS COORDINATION PROGRAMS.

(C) (1) ON OR BEFORE JANUARY 1, 2026, THE OFFICE AND THE COORDINATOR SHALL ENTER INTO A MEMORANDUM OF UNDERSTANDING WITH THE MARYLAND DEPARTMENT OF HEALTH, THE DEPARTMENT OF HUMAN SERVICES, AND ANY OTHER RELEVANT STATE AGENCY FOR THE SHARING AND STORAGE OF INFORMATION AND DATA RELATED TO PEDIATRIC HOSPITAL OVERSTAY PATIENTS AND CHILDREN IN UNLICENSED SETTINGS IN THE STATE.
(2) THE MEMORANDUM OF UNDERSTANDING SHALL GOVERN THE ACCESS, USE, MAINTENANCE, DISCLOSURE, AND REDISCLOSURE OF PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH FEDERAL AND STATE LAW, INCLUDING THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.
(D) THE COORDINATOR SHALL:
(1) WORK INDEPENDENTLY AND IMPARTIALLY, WHILE MAINTAINING APPROPRIATE PATIENT CONFIDENTIALITY, TO ADVOCATE ON BEHALF OF PEDIATRIC HOSPITAL OVERSTAY PATIENTS AND CHILDREN IN UNLICENSED SETTINGS;
(2) MANAGE A NEEDS ASSESSMENT OF PLACEMENT AND CLINICAL RESOURCES, LOOKING AT WHAT THE NEEDS ARE IN THE SYSTEM AND WHAT AND HOW MANY RESOURCES THE CHILDREN NEED,

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~~(2)~~ (3) REVIEW POLICIES AND PROCEDURES OF RELEVANT STATE AGENCIES AND MAKE RECOMMENDATIONS FOR NECESSARY CHANGES TO THE POLICIES OR PROCEDURES TO BETTER SERVE PEDIATRIC HOSPITAL OVERSTAY PATIENTS AND CHILDREN IN UNLICENSED SETTINGS; AND

~~(3)~~ (4) MAINTAIN DATA ON EACH PEDIATRIC HOSPITAL OVERSTAY 16 PATIENT, INCLUDING: INCLUDING:

(I) THE PATIENT'S LENGTH OF STAY;

(II) THE RESPONSIBLE STATE AGENCY, INCLUDING THOSE PATIENTS FOR WHOM A STATE AGENCY HAS RESPONSIBILITY FOR MAKING A PLAN, IF APPLICABLE;

(III) SERVICES NEEDED;

(IV) PLACEMENT OPTIONS BEING ~~SOUGHT BY THE PATIENT~~ RECOMMENDED ON BEHALF OF THE PATIENT;

(V) INFORMATION REGARDING PREVIOUS HOSPITAL ADMISSIONS FOR A BEHAVIORAL HEALTH DIAGNOSIS AND/OR DEVELOPMENTAL DISABILITY, INCLUDING AUTISM; AND

(VI) ANY OTHE RELEVENT INFORMATION, INCLUDING DIAGNOSES, RACE, AGE, EDUCATIONAL NEEDS, ETC.

(E) ON OR BEFORE OCTOBER 1 EACH YEAR, BEGINNING IN 2026, THE COORDINATOR SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 26 2–1257 OF THIS ARTICLE, THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE ON THE NUMBER OF PEDIATRIC HOSPITAL OVERSTAY PATIENTS AND CHILDREN PLACED IN UNLINCENSED SETTINGS IN THE STATE AND DE–IDENTIFIED INFORMATION RELATED TO ACTION PLANS IN PLACE TO ACHIEVE APPROPRIATE PLACEMENTS; PLANS TO END THE PRACTICE OF CHILDREN RESIDING IN HOSPITAL OVERSTAYS AND UNLICENSED SETTINGS, DATA THAT INFORMS HOW THE PLANS WILL BE IMPLEMENTED, AND THE ANTICIPATED DATE WHEN THE PRACTICES WILL CEASE.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Department of Health shall:

(1) review the reimbursement rates paid to residential treatment centers and respite care facilities in the State and determine the reimbursement rate that would be necessary to cover the cost of care and prevent future bed closures in residential treatment centers and respite care facilities in the State; and

(2) study the implementation of a prospective payment model for residential treatment centers and respite care facilities in the State with the goal of incentivizing the expansion of residential treatment center and respite care facility capacity in the State.

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(b) On or before December 1, 2025, the Department shall report the findings and recommendations from the review and study conducted under subsection (a) of this section to the Governor and, in accordance with § 2–1257 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2025.

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Education Advocacy Coalition

for Students with Disabilities

SENATE FINANCE COMMITTEE

SENATE BILL 696: PUBLIC HEALTH—PEDIATRIC OVERSTAY PATIENTS

DATE: FEBRUARY 18, 2025

POSITION: LETTER OF INFORMATION

Disability Rights Maryland (DRM) the protection and advocacy for Maryland, is federally mandated to defend and advance the civil rights of people with disabilities. DRM works to ensure that all individuals with disabilities in Maryland receive the services and supports they need to live and participate in their communities. DRM submits this letter of information to identify issues for the Committee as you consider Senate Bill 696, which is intended to address pediatric hospital overstays.

In 1987, DRM filed *Lisa L. v. Wilzack*, a class action lawsuit, on behalf of children and youth stuck in public psychiatric hospitals beyond their discharge date. The case settled in 1993, and the state successfully resolved the overstay problem. However, over the past six years or so, overstays began to recur, with dozens of children in overstay status, often for weeks or months at a time. With no solution on the horizon, DRM became a plaintiff, as well as co-counsel, in *T.G. et.al. v. Maryland Department of Human Services, et al.*, a class action lawsuit filed in May, 2023 on behalf of foster children in hospital overstay status. The case is pending; the State's motion to dismiss was denied in part, and the parties are currently in discovery. During the pendency of this suit, the number of children in overstay status has increased. Numbers alone do not tell the full story, however. Each child in overstay is a child who is not getting access to school, to time outside, to friends and family or to meaningful treatment.

Although many children in overstay status are recommended for residential treatment centers, this number is misleading; DRM has been told on numerous occasions that hospital staff have recommended residential treatment center placements because they did not know there were alternatives such as therapeutic foster care or because they were pressured into issuing a certificate of need by the local department of social services social worker. The majority of children and youth recommended for residential treatment center placements return to the community and do well; they do not need the restrictiveness of residential treatment placements if supports and services are provided to them in community placements such as therapeutic foster care or group homes.

The issue of hospital overstays persists in part because the state of Maryland has not used approaches that have worked in other states, such as wraparound services and crisis prevention and intervention services. DRM strongly advocated for Maryland's adoption of START, an evidence-based crisis prevention and intervention program utilized in about a dozen states throughout the country. After several years, the state agreed to implement a pilot program

with minimal components of the START program; however, the state did not put even these components in place in a meaningful way. Families have been waiting for more than a decade for wraparound services that might enable them to keep their children home with them and keep their families together. It is important for state officials and policymakers to recognize that a placement crisis exists and that the Section 1915(i) waiver, which enables some families to receive home-based mental health services, does not solve the problems caused by the lack of wraparound services.

Senate Bill 696 is intended to address the hospital overstay issue by adding beds to the two regional institutes for children and adolescents (RICAs) and by allowing concurrent applications to in-state and out-of-state residential programs. Focusing on residential treatment raises several issues that need to be considered.

First, on May 13, 2024, the United States Senate Committee on Finance issued "Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities", a report finding rampant abuse and neglect in residential facilities owned by Acadia, UHS and Vivant, three for-profit, private equity-owned companies, and Devereux, a nonprofit company. Maryland has a long history of sending children and youth to Acadia, UHS and Devereux facilities outside the state. Since 2019 alone, the Board of Public Works has approved, for millions of dollars, 19 Acadia, 3 Devereux and 34 UHS contracts sought by the Department of Human Services. The Board of Public Works has approved many additional out of state programs run by other companies, some of them for-profit. In 2015, the state had to bring more than 30 children back from AdvoServ in Delaware after the death of a Maryland teen. Soon after, the state emergently returned several youth from the Eagleton School in Massachusetts after a federal raid shut down the facility. Maryland also returned a number of youth from the Woods School in Pennsylvania because of quality of care concerns. The Senate Finance Committee concluded that congregate care does not work and strongly recommended the provision of community services as an alternative.

Additionally, in its capacity as the protection and advocacy organization for Maryland, DRM has received numerous complaints over the years about RICA Baltimore and RICA Rockville. DRM is concerned that a proposal to expand beds in these facilities to address hospital overstays instead of working with community providers to focus on wraparound services, crisis prevention and intervention, expansion of therapeutic community placements and other supports will not solve the overstay problem; for children and youth who can be served in less restrictive settings, placement at RICA or in an out-of-state program may well violate their rights under the Americans with Disabilities Act.

DRM asks the Committee to consider these points in your deliberations about Senate Bill 696. Moving children in overstay status to restrictive residential treatment programs with a history of abuse and neglect of children has ramifications that cannot be ignored.

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