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Delegate Josephine A. Pena-Melnyk
Chair, House Health and Governmental Operations Committee
240-41 Taylor House Office Building
Annapolis, MD 21401

Re: **HB 962 (2025): SUPPORT WITH AMENDMENTS**

Dear Chair Pena-Melnyk and Members of the Committee:

I support HB 962, "Public Health – Pediatric Hospital Overstay Patients," but with amendments, and urge the Committee to issue a favorable report *if* HB 9g2 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 were called. We wrote to the DHS Secretary about this as soon as we heard of it, and, within a week, he was

[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.*

moved 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 was 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) (Attachment 2). 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 be 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. In addition, the Committee should not accept MDH and DHS' proposed amendments. In particular:

E. The Committee should not accept MDH and DHS's request to revise the bill's overstay trigger from 24 hours to 48 hours. The *L.J. v. López* modified consent decree defines an overstay being housed for at least **four hours** in an unlicensed facility. DHS agreed to this standard in 2009. Why should they be permitted to redefine the standard, to the massive injury of

[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",

the children now, when they have failed to fix a problem that has been occurring since 2019 or earlier? Discharge planning should commence immediately upon a foster child's placement in a hospital. A placement should already be planned. There is no reason why the State should get 48 hours grace when it hasn't done the requisite planning the child needs.

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

Respectfully submitted,

/s/ Mitchell Y. Mirviss