



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

FEB 16 2007

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
131 Lowe House Office Bldg.
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chairman
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chairman
House Health and Government
Operations Committee
161 Lowe House Office Bldg.
Annapolis, MD 21401-1991

RE: HB 771 – Department of Health and Mental Hygiene – Therapeutic Behavioral Services – Rate Adequacy Study (Ch. 351 of the Acts of 2006)

Dear Chairmen Currie, Conway, Middleton and Hammen:

In accordance with of Section 1 of HB 771 – *Department of Health and Mental Hygiene – Therapeutic Behavioral Services – Rate Adequacy Study*, the Department submits this report on the adequacy of rates paid to therapeutic behavioral services providers. The Mental Hygiene Administration (MHA) and the Office of Health Care Financing (Medicaid) jointly fund and supervise the provision of therapeutic behavioral services (TBS).

Therapeutic behavioral services are intensive rehabilitative services intended to restore the child or adolescent's previously-acquired behavioral skills and provide the consumer with behavioral management skills to effectively manage the behaviors or symptoms that place the consumer at-risk of requiring a higher level-of-care. TBS is intended to supplement other specialty mental health services by addressing and resolving the targeted behavior(s) or symptom(s) that are jeopardizing their current living situation. Children and adolescents who receive TBS must have an initial assessment conducted by the TBS provider who is responsible for the development and implementation of a behavioral plan that includes goals and treatment interventions. TBS involves a one-to-one therapeutic intervention by a trained provider, known as a TBS "aide." The aide provides modeling, structure, support and immediate, frequent one-to-one behavioral intervention, which assists the child in changing or managing target behaviors. The majority of the staff providing the direct care are not licensed healthcare workers. Any unlicensed aide must be supervised by licensed staff and at a minimum, must meet with the aide at the site of the TBS to ensure services are being provided in accordance to the behavior plan.

Individualized behavioral interventions that are provided include support for and work with the parent/caregiver to assist them in providing new ways of managing problem behavior and ways of increasing the kinds of behavior that will allow the child to achieve his or her treatment goals. Each child must also be reassessed periodically by the TBS provider, which includes a re-evaluation of the behavior plan, progress and efforts made towards completing the identified goals, and a new plan that incorporates the behavioral needs and request for hours of service to achieve his or her treatment goals. Each child must also be reassessed periodically by the TBS provider, which includes a re-evaluation of the behavior plan, progress and efforts made towards completing the identified goals, and a new plan that incorporates the behavioral needs and request for hours of service.

Under the definition of TBS, the children who receive the service have behaviors that are challenging to manage in the current environment. The provider of TBS delivers service on a one-to-one basis in the home or other community setting. Even though these services are to be provided to children who have been determined that they could safely be managed in the community, their behaviors can be aggressive at times. It becomes imperative that the staff is skilled and well trained in the behavioral plan that is to be implemented.

Medicaid has been providing TBS to children for the past several years at a rate of \$20 per hour for one-on-one aide services and \$100 for the initial assessment of the child. In November 2005, the Medical Care Program promulgated regulations to codify these already-established rates. In addition, a rate of \$94.00 was established for the required periodic re-assessment of the child. The regulations also include the requirement that the actual worker providing TBS must either be a licensed healthcare provider or if not licensed, supervised by a licensed provider with on-site supervision occurring once every 60 days.

According to HB771, the study shall assess the impact of the current rates on providers (advocates have stated that the hourly rate was too low to meet the requirements of providing the salary, fringe, training, supervision by licensed professionals, and to cover administrative costs). In addition, the legislation requires the Department to assess the impact of the current rates on:

- 1) the participation of existing and potential therapeutic behavioral services providers;
- 2) the ability of TBS providers to recruit and retain staff;
- 3) the ability of the Department to promptly refer a child for receipt of TBS; and
- 4) the ability of TBS providers to deliver the requisite number of therapeutic behavioral services hours.

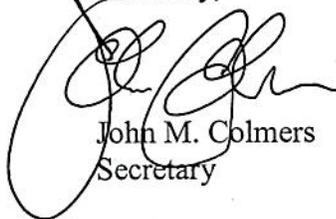
The Department is also required by HB 771 to solicit input from TBS providers, mental health professionals, advocates, and families of children receiving TBS. In order to gather this input, the Medical Care Program (Medicaid) and MHA jointly conducted a meeting in August 2006 with the TBS providers, mental health professionals and advocates to identify their

concerns with the current rate structure. At the meeting, providers also stated that it is difficult to maintain well-trained staff, and to meet the hours of authorized services. Providers recommended increasing the hourly rate by \$5 to \$25, indicating that \$25 per hour would be enough to retain qualified staff and provide the hours of needed services.

In addition to the hourly rate, providers identified as a barrier to providing services the rate for the Reassessment. Providers have indicated that the \$94 rate for the reassessment does not provide money for the face-to-face on-site supervision of the aide, as well as the evaluation and development of a new behavior plan. Some providers indicated that the reassessment rate should be increased to \$250-\$287 to include all of these costs. Other providers recommended establishing a rate specifically for the on-site supervision (i.e., \$125 twice per 60-day period). The need for supervision is only required when the aide is not a licensed professional. One other recommendation was to change the regulations to allow aides to be individuals who carry a licensed level in the state, but are not allowed to practice under that license without supervision (such as licensed graduate or associate-level social workers). The Department notes that all comments regarding rates were anecdotal information. A detailed rate study or review of providers' certified financial reports was not performed. The Department would require an outside consultant to perform those tasks if necessary.

Copies of all written comments are attached to this report. If further information is required, please contact Brenda Rose, Deputy Director of the Acute Care Administration, at (410) 767-5204.

Sincerely,



John M. Colmers
Secretary

Attachment

cc: Diane Herr
Brenda Rose
Stacey Diehl
Susan Steinberg



MARYLAND DISABILITY LAW CENTER

October 26, 2006

Brenda Rose
Deputy Director
Office of Health Services
Medical Care Programs
201 West Preston Street
Baltimore, MD 21201

RE: Study on Therapeutic Behavioral Services under House Bill 771

Dear Ms. Rose:

I am writing to you to provide input for the study that the Department is conducting into the rate for Therapeutic Behavioral Services (TBS) and the report that you will be submitting to the General Assembly as required by House Bill 771 (2006). As you know, MDLC and the provider community have previously written to the Department on a number of occasions about the inadequacy of the \$20 hourly rate for TBS. I have enclosed the most recent letter from MDLC on this subject dated May 24, 2005.

I write now to provide you with recent data that provides a count of the number of individuals who have received Therapeutic Behavioral Services (TBS) by county under Medical Assistance during the past two fiscal years. It was recently provided to MDLC by the Mental Hygiene Administration in response to a Public Information Act request. I am asking that you include the attached chart, this letter, and its attachments in the Joint Chairman's Report to be submitted by DHMH as mandated by House Bill 771 (2006).

MDLC has informed DHMH on many occasions that the \$20 hourly rate for TBS services is inadequate and results in many children being unable to obtain this service at all or only after long delays where they may be rehospitalized at great cost to the State. The enclosed chart confirms that very few children in Maryland have been able to access TBS services in the past two years and that there are many counties where the service is either not available at all or where very few children receive it. The number of children in the entire State able to access this service in fiscal year 2006 was 488 and the number was less than half of that or only 193 children in fiscal year 2005.

While it is impossible to know with any certainty how many of the 408,575 individuals on Medicaid under 21 years of age (as of March 2006) could benefit from TBS, national data suggests that thousands of Maryland children -- certainly many more than the 488 children who received it -- would be eligible. The latest available data from the federal Center for Mental Health Services estimates that between 10-12% of youth in Maryland will have a serious emotional disturbance (SED) and 6-8% will be extremely impaired. Children with serious emotional disturbances have complex needs requiring high intensity community-based services to prevent repeat hospitalization and/or institutional placement. In addition to these children with SED, another group of children, those with developmental disability diagnoses and

MARYLAND DISABILITY LAW CENTER
1800 North Charles Street, Suite 400, Baltimore, MD 21201
410.727.6352 • 800.233.7201 • 410.727.6389 fax • 410.727.6387 tty

October 26, 2006 Letter from Cathy S. Surace to Brenda Rose
Page Two

behavioral problems also are eligible for TBS. The fact that only 1% of children in our Public Mental Health System (488 out of 45,755) and only .1% of children on Medical Assistance are utilizing TBS services suggests a considerable level of unmet need for these high need youth and raises concerns about whether youth have access to appropriate levels of care.

The attached data from the Mental Hygiene Administration also reveals that most of the children receiving this service are congregated in the Baltimore Metropolitan area while children in the remainder of the State are either unable to access this service at all or access it in far fewer numbers than might be expected given the number of persons under 21 from those counties on Medical Assistance. This is in large part due to the location of TBS providers in Baltimore and the fact that there are no TBS providers serving many parts of the State, particularly those areas where travel distances would make it unfeasible to deliver the service given the current reimbursement rate.

While there may be other reasons for the low number of children receiving TBS and the congregation of those children in the Baltimore Metropolitan area, the \$20 hourly reimbursement is undoubtedly a major factor. After years of recruiting providers statewide to deliver this service at the current rate, DHMH has been unsuccessful in attracting a group of providers that together are able to serve the entire State or even large parts of it. Providers such as Villa Maria have informed the State that they are unwilling to become TBS providers because the \$20 hourly rate would not cover the cost of providing the service.

We believe the attached count of TBS recipients by location is most relevant to your consideration of the need for a significant rate increase in TBS services and illustrates that the State's effort to recruit providers to deliver these services on a statewide basis at the current rate has failed.

Sincerely,



Cathy S. Surace
Managing Attorney

Count of Children Receiving Therapeutic Behavioral Services by County

Based on Claims Paid Through 09/18/2006

County	FY 2005	FY 2006
ANNE ARUNDEL	8	25
BALTIMORE CITY	147	333
BALTIMORE COUNTY	15	72
CARROLL	2	5
CECIL	0	1
GARRETT	1	2
HARFORD	4	9
HOWARD	1	9
MONTGOMERY	3	7
PRINCE GEORGES	5	6
QUEEN ANNE	1	0
SOMERSET	5	5
WASHINGTON	1	1
WICOMICO	0	9
WORCESTER	0	4



May 24, 2005

Ms. Brenda Rose
Acute Care Administration
Office of Health Services
Department of Health and Mental Hygiene
201 W. Preston St., Suite 200
Baltimore, MD 21201

RE: Inadequacy of Hourly Rate for Therapeutic Behavioral Services
Request for Medicaid Rate Analysis

Dear Ms. Rose:

When we spoke at the Children's Blueprint for Mental Health conference on April 7, 2005, I was pleased to learn that the Department of Health and Mental Hygiene (DHMH) is re-examining the rate for one-to-one Therapeutic Behavioral Services (TBS) as a part of the development of the regulations for TBS. MDLC supports the additional reimbursement you stated that the Department is considering for periodic clinical evaluation and updating of the behavior plans.

However, I wanted to follow-up with you regarding your statement that the \$20 per hour rate for TBS is adequate for the delivery of the service by the one-to-one aide and for supervision of the aide.

In reaching this conclusion, the Department has ignored the consistent feedback it has received from the provider community and MDLC that the \$20 rate is inadequate. I have attached recent letters from the Community Behavioral Health Association of Maryland, Villa Maria, and Humanim all pointing to evidence of the inadequacy of the rate. I also know that the Department has received letters and verbal feedback in the past consistently informing you that \$20 per hour is not sufficient to deliver this service. I have attached past letters from Humanim, Villa Maria, the Community Behavioral Health Association of Maryland, and the Maryland Association of Community Services.

You said that the rate was reasonable to reimburse an unlicensed aide working with a child in the home in light of the fact that the hourly rate for private duty nursing is \$28. However, the inadequacy of the rate for one service, such as nursing, does not justify or excuse an inadequate rate for another Medicaid service such as TBS.

There is mounting evidence that many providers are unwilling to deliver TBS while those willing to participate are having financial difficulty in delivering it and face persistent problems hiring and retaining staff leading to long delays in service delivery.

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Medicaid services must be provided with "reasonable promptness," and the state has a duty to maintain an adequate array of providers. The current rate for TBS does not ensure that an adequate array of providers exists so that children receive the service with "reasonable promptness," or even within the timeframes specified by the Mental Hygiene Administration regulations. *See* COMAR 10.09.70.07F (Services should be initiated within 10 to 30 days after authorization or sooner if the need is urgent.).

For example, I am currently working with a family whose child was referred for TBS on September 13, 2004, but who still does not have a TBS aide for the recommended number of hours. J.G. was referred for TBS upon discharge from Johns Hopkins Hospital. For months, despite the need for the service, his guardian heard from no one. She sent a follow up letter to the Health Choice and Acute Care Administration, MHA, DDA, MAPS-MD, and the CSA. The child was rehospitalized at Sheppard Pratt on February 1, 2005. His social worker and psychiatrist at Sheppard Pratt also followed up with MAPS-MD regarding the September 13, 2004 request for TBS, documenting his continued need for the service.

On February 17, 2005, our client's guardian heard from Humanim that MAPS-MD referred the case to them. This was 5 months after the professional referral for TBS was made. Humanim went to our client's home to do the initial assessment and develop a behavior plan on March 4, 2005. However, due to the inadequacy of the hourly rate, Humanim has been unable to recruit and hire an aide to render the hours our client needs. Also due to the hourly rate, Humanim is unable to keep a pool of available individuals on staff but instead recruits and hires TBS aides when they receive referrals.

On April 26, 2005, Humanim began to provide three hours of TBS to J.G. on Tuesdays and Saturdays. At this time, Humanim has hired an aide to work with him, and anticipates that she will be trained and available to work thirty to thirty-five hours per week by the end of May. Meanwhile, J.G. was rehospitalized two additional times.

Had J.G. received TBS with reasonable promptness as required by federal law, or even within the timeframes prescribed by Maryland's own regulations, the three psychiatric hospitalizations might not have been necessary.

Adequate hourly rates are necessary to make TBS a reality for children at risk of utilizing higher levels of care. Children at risk of psychiatric hospitalization and residential treatment center care should not have to wait for over seven months to access services designed to prevent the need for hospitalization. As J.G.'s case illustrates, the delivery of services in this manner will not serve the intended purpose of guarding against costly out-of-home placements.

Almost two years ago, the Governor's Council on Custody Relinquishment released a September 2003 Report, approved by the Governor, that recommended that DHMH do a

Letter to Ms. Brenda Rose
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Medicaid rate analysis for several key Medicaid services including TBS. *See Enclosed Excerpt.* The recommendation called for the analysis to be done in an "open manner with notice to and input from service providers, families, and advocates." This recommendation was slated for "immediate implementation" but it appears to have been overlooked. Instead, DHMH continues to maintain that the rate for TBS is adequate without conducting the necessary rate analysis.

Therefore, MDLC requests that DHMH now conduct this Medicaid rate analysis for TBS as soon as possible, and that you explain in writing your position that the \$20 hourly rate for TBS services is adequate in the face of the mounting feedback DHMH has received from providers to the contrary. In preparation for the Medicaid rate analysis, MAPS-MD should be asked to provide the Department with all relevant data including records indicating the average length of time from the date of professional referral for TBS services to the date of a child's actual receipt of the service.

I would appreciate a response to this letter within the next thirty (30) days.

Sincerely,



Lucy Shum
Staff Attorney

enclosures

cc: S. Anthony McCann
M. Teresa Garland
Brian Hepburn
Diane Coughlin

RECEIVED MAY 20 2005

HUMANIM

the human spirit of one...the compassion of many

May 17, 2005

Brenda Rose
Acute Care Administration
Office of Health Services, DHMH
201 W. Preston Street, Suite 200
Baltimore, MD 21201

Dear Ms. Rose:

I am writing on behalf of Humanim, a community mental health and developmental disabilities services provider. Humanim currently provides Therapeutic Behavioral Services (TBS) to approximately 80-100 individuals per year. It is our understanding that DHMH is considering funding increases of one-to-one TBS, although rather than increasing the hourly rate, a payment for a periodic clinical evaluation to update the behavioral plan is being considered. Offering funding for an updated clinical evaluation is unlikely to be helpful in enticing providers to offer these services or assist them in delivering services in a cost effective manner.

I am writing to advocate for a substantial increase in the hourly rate structure. Humanim is currently evaluating our ability to continue providing this service as it is very difficult to even break even under the current rate structure. It is virtually impossible to offer these services unless the provider only utilizes part-time direct care staff (who are far more difficult to recruit and maintain) as the rates cannot adequately cover direct care salaries, benefit costs, case management staff, and overhead. In addition, it is increasingly difficult to attract, hire, and maintain qualified staff that are willing to work at low wages to provide very intensive services. Consequently, the recruitment costs and direct care supervisory demands of providing this service are very high.

The current reimbursement rate only allows for billing for direct points of contact between the hired staff and client. The direct care staff receives over 50% of the \$20.00 an hour rate, with an average hourly rate of 10.50 an hour. This does not include the benefit costs which run at approximately 20% for full-time staff.

There is no reimbursement covering the following areas:

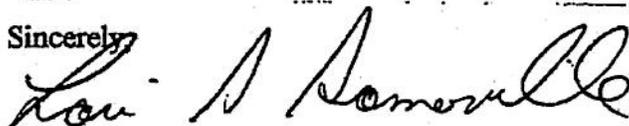
- a) Initial intake meeting (usually a 2 hour process plus several hours of coordinating a case beyond initial intake)
- b) Case coordinators who spend several hours a week on any given case and on supervision of the direct care staff

- c) Authorizations and direct points of contact with APS (approximately 15 hours a week)
- d) Staff training: Full-time staff receives approximately 56 hours of training initially and a minimum of 12 hours for every year to follow. Part-time staff receive 40 hours initially and a minimum of 12 hours every year to follow.
- e) Recruitment costs: advertising, drug screens, background checks, interviewing, etc.
- f) Mileage costs
- g) Management, administration, and overhead costs: including TBS Program Manager, Program Director, Psychology Associate, rent, utilities, accounting costs, billing staff, HR staff, supplies, etc.

It should be noted that each case requires the same amount of attention (i.e. reports, staff supervision, IRPs) regardless of the number of hours of direct service provision. Because there is no reimbursement for case management and the hourly rate is inadequate to cover these services, case coordinators are often unable to involve themselves with families in ways that might otherwise be highly beneficial (i.e. attending IEP meetings, investigating resources for families, etc.). Additional case management services could be worked into the current services if the rate was increased and/or a case management billing structure was incorporated. Many families lack good wrap around services and case management. An increase in the rate would give providers more flexibility in their role with the individuals and families served, ultimately increasing value to the individual served and their families and decreasing long-term costs by offering a more proactive service package.

Without an increase in hourly rates for this service, I do not believe community providers can continue to provide the level of service these children and their families rightfully deserve.

Sincerely,



Lori Somerville
Chief Operating Officer

Cc: Brian Hepburn MD., Director, MHA
Diane Coughlin, Director, DDA
Lucy Shum, MDLC

April 29, 2005

Brenda Rose
Acute Care Administration
Office of Health Services
Department of Health & Mental Hygiene
201 West Preston Street
Suite 200
Baltimore, Maryland 21201

*Other Villa Maria
Continuum Programs*

Baltimore Child and
Adolescent Response
System (B-CARS)

Behavioral Health Clinics
Bridges to Success

Head Start Consultation

Home-Based Respite

In-Home Intervention

Parochial School
Consultation

Project Prepare

Residential Treatment
Center

Safe Start

Therapeutic After School
Programs

School-Based Mental
Health

Therapeutic Group Home

Therapeutic Respite

Type III Diagnostic
Program

Villa Maria School

White Oak Counseling
Services

Dear Ms. Rose,

I had the opportunity to sit in on the workshop that you and Lucy Shum from MDLC presented at the Children's Mental Health Conference on April 7, 2005. During the workshop several participants spoke about the need for expanded capacity for one-to-one therapeutic behavioral aide services. You will recall that these individuals referenced the difficulties that they have had in obtaining this resource for their clients, and that a number of clients are on waiting lists for this service. When I mentioned that a number of providers are also frustrated because they recognized the value of this service but are unable to develop capacity because of the current reimbursement rate, Barbara Francis (who was in the audience), indicated that DHMH was reevaluating the hourly rate.

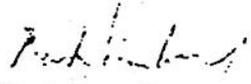
Could you please provide me with an update on the status of your discussions about the fee for this service? Our agency recognizes that one-on-one therapeutic behavioral support could be an important, and in some cases a critical, service for a number of the families we work with. We would like to add the development of this intervention to our strategic goals for the next fiscal year, and therefore we are interested in knowing whether rate adjustments are in the works.

Many of the children we work with exhibit challenging and at times aggressive and sexualized behaviors. We believe that working one-on-one in the home of an adolescent with serious emotional disabilities is a risky proposition. We would be hesitant to provide this service unless we could deploy skilled and experienced staff with sufficient clinical support and backup. We do not believe that the current hourly rate comes close to the cost involved in providing this type of service to the children and families we work with. The current rate does not begin to cover the cost of the salary (including night shift differential), benefits, transportation costs, training of the one-to-one behavioral health aide staff, and the supervision, backup coverage, billing costs and other administrative costs

(e.g. insurance, cell phone, record keeping, recruitment, payroll, etc.) that we would incur if we added this service to our continuum.

Unfortunately, until an adjustment is made to the fee for one-to-one behavioral health aides, we can not consider bringing up this service for the children we serve. Thank you

Sincerely,



Mark Greenberg
Administrator

cc: Lucy Shum J.D.
Albert Zachik M.D.

COMMUNITY BEHAVIORAL HEALTH

CBH

ASSOCIATION OF MARYLAND

RECEIVED MAY 5 2005

May 4, 2005

Brenda Rose
Acute Care Administration
Office of Health Services, DHMH
201 W. Preston Street, Suite 200
Baltimore, MD 21201

Dear Ms. Rose:

CBH is the professional association for Maryland's network of community mental health programs serving children and adults who use the Public Mental Health System (PMHS). Several of our members are approved to deliver one-to-one Therapeutic Behavioral Services (TBS) to children; more would provide TBS if the reimbursement rate were higher.

We understand that DHMH is considering an expansion of the TBS service but not an increase in the \$20 hourly rate. We urge you to raise this rate by at least 100% to bring reimbursement closer to actual cost.

The following are comments from current providers of TBS and those who have considered the service:

- "Not adequately funding TBS creates a gap in the array of service needed to adequately develop and implement a wraparound model. The low rate in conjunction with reducing RTC beds and at the same time cutting (both in rate and access) child and adolescent psychiatric rehabilitation, seems to be contradictory to the directions that we are being asked to pursue. The rate needs to be closer to about \$54.00 for any viability."
- "The lower the pay scale the less training and skill the TBS worker has. This level of employee is our most problematic with the highest turnover, requiring new training, etc."
- "We are strongly considering whether to continue this service as it is very difficult to break even. In March, we lost money – our YTD position for these services is barely break even (on slightly over \$1,000,000 in TBS revenue). It is virtually impossible to offer these services unless you are using only part-time direct care staff as the rates cannot adequately cover direct care salaries, benefit costs, case management staff, and overhead. I don't think that offering funding for an updated clinical evaluation is going to be at all helpful in enticing providers to offer these services."

CBH IS A STATEWIDE NETWORK OF COMMUNITY SERVICE AGENCIES.

18 Egges Lane • Catonsville, Maryland 21228-4511 • 410-788-1865 • fax: 410-788-1768
Member of IAPSR and NCCBH

- "The reimbursement rate includes only direct points of contact between the hired staff and client. The direct care staff receives over 50% of the \$20 per hour rate, with an average hourly rate of \$10.50 an hour. This does not include the benefit costs which runs at approximately 20% for full-time staff. There is no reimbursement covering the following:
 - a. Initial intake meeting (usually a 2 hour process plus several hours of coordinating a case beyond that).
 - b. Case coordinators who spend several hours a week on any given case and on supervision of the direct care staff.
 - c. Authorizations and direct points of contact with APS (approximately 15 hours a week).
 - d. Staff training: full-time staff must receive approximately 56 hours of training initially and 12 hours for every year to follow; part-time staff receive 40 hours initially and 12 hours every year to follow.
 - e. Recruitment costs: advertising, drug screens, background checks, etc.
 - f. Mileage costs.
 - g. Management/admin/overhead costs: including Program Manager, Program Director, Psychology Associate, rent, utilities, accounting costs, billing staff, HR staff, supplies, etc.

It should be noted that each case requires the same amount of attention (i.e. reports, staff Supervision, IRPs) regardless of the number of hours being provided with direct care staff."

With the decimation of child and adolescent rehabilitation services by the Mental Hygiene Administration over the past two years – the number of children served dropped from 8700 to 1800 – TBS has the potential for filling a critical void, but the reimbursement must be increased.

Sincerely,



Herbert Cromwell
Executive Director

cc: Brian Hepburn M.D., Director, MHA
Diane Coughlin, Director, DDA
Lucy Shum, MDLC

HUMANIM
The Human Services Company

January 21, 2003

SENT CERTIFIED RETURN RECEIPT

Mr. Joseph Davis, Executive Director
Office of Operations
Department of Health & Mental Hygiene
201 West Preston Street
Room SS9
Baltimore, MD 21201

Dear Mr. Joseph Davis,

I am writing on behalf of our Board of Directors regarding the funding of several hundred children and adults with disabilities. Humanim is a not-for-profit human service organization that has been serving individuals with disabilities for over 30 years. As part of our ongoing commitment and mission Humanim has concentrated on providing programs serving "difficult to serve" populations.

Over a year ago we undertook a special project for the State of Maryland to assist the State and the Maryland Disabilities Law Center. A Humanim program was established to serve those children and adults in serious need under the Expanded Early and Periodic Screening Diagnosis and Treatment Program (EPSDT). As you may be aware, Humanim is the primary provider of these services for the State of Maryland. Humanim has provided these services to 66 consumers with the expectation that we would receive a rate of \$40.00 per hour. We have now been informed that the rate is \$20.00 per hour. I am writing to ask your help in resolving this matter.

The following is a brief history of the issue:

Cora House, our Director of Client Accounting was verbally told by Alisa Davis, Nurse Consultant, for the Division of Children Services on September 9, 2002 that Medical Assistance would reimburse us for Therapeutic Services, (Code W9115) at a rate \$40 per unit. Cora asked Ms. Davis if she was sure of the \$40.00 rate for those with a developmental disability, since MHP was reimbursing us at \$20.00 hour for those with only a mental health diagnosis. Ms. Davis then confirmed the \$40.00 rate for individuals who had a primary diagnosis of a developmental disability but who may also have a mental health diagnosis.

In addition, on September 11, 2002, Cora House and our Client Accounts Coordinator, Sharon England attended a training given by your department on billing claims to

Medical Assistance. Cheryl Gresham of the Medical Care Liaison Unit, Office of Operations and Eligibility with the Maryland Medical Care Program distributed materials specifically related to EPSDT. The rate structure materials that were distributed documented the \$40.00 rate for Therapeutic Services (Code W9115); further confirming Cora's conversation with Ms. Davis.

After applying for MA numbers and buying and installing special software at our expense based on your department's recommendation Humanim starting submitting claims going back to 07/01/01.

On December 2, 2002 Cora House received an adjudication report showing that the claims were processed at \$20.00 per hour and not \$40.00.

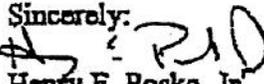
Humanim is now being told that the information given out both verbally and in writing is incorrect. Kimberly Folkes, Division Chief of Provider Relations also stated that the \$20 reimbursement rate had been in effect since July 1997 and that it has taken five years to bring your system up to date. This was done on 7/11/02.

On December 6, 2002 Ms. Folkes also told Cora House that Alisa Davis is completing a "review for referred service listing to update pricing info both on system and the distribution info that go out to the providers. Alisa has to get the Deputy Director in her area to sign off on this bill and Kimberly will get me a copy of it at that time".

The impact of this decision regarding this change from \$40.00 to \$20.00 for our Therapeutic Intervention Program is would be a loss of approximately \$352,707 for fiscal year 2002 and a loss of \$395,370 for our postings to date in the fiscal year 2003.

I am asking that you please look into this matter and at your earliest convenience get back to me. The fiscal year 2002 audit is currently on hold because of the magnitude of this issue. I am hoping that you can assist us in resolving this discrepancy in rates so that future EPSDT services will not be jeopardized. Thank you for your time and attention to this matter.

Sincerely,


Henry E. Posko, Jr.
Chief Executive Officer and President

cc:

Jill A. Hudock, CPA, Executive Vice-President and Chief Financial Officer
Lori Somerville, Executive Vice-President and Chief Operating Officer
Cora House, Director of Client Accounting



The Community Behavioral Health Association of Maryland, Inc.

*Formerly The Maryland Association of Psychiatric Support Services and
The Maryland Council of Community Mental Health Programs*

October 24, 2002

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Ms. Cathy Surace
Maryland Disability Law Center
1800 N. Charles Street, 4th Fl.
Baltimore, Maryland 21218

Dear Cathy:

CBH has concerns about the efficacy of the Mental Hygiene Administration's Therapeutic Behavioral Support service as described in the proposed regulations. A significant concern is that the \$20 rate is much too low to sustain effective interventions focused on assisting a child to succeed in school and in other community-based environments.

Our Child and Adolescent Committee is reviewing the regulations and we will likely have additional comments.

Sincerely,

Herbert S. Cromwell
Executive Director

The Maryland Association of Community Services (MACS)
for Persons with Developmental Disabilities, Inc.
877 Baltimore Annapolis Blvd. Suite 111 ■ Severna Park MD 21146
410-518-9874 (Baltimore/Annapolis); 301-261-1027 (DC Metro); 410-518-9875 fax
http://www.macsonline.org Email: macs@macsonline.org

October 30, 2002

Michelle Phinney
Dept. of Health & Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Ms. Phinney:

I write to comment on the proposed regulations 10.09.37 governing Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Referred Services. Many of the agencies within our membership provide such services to children who are intended recipients of these interventions.

The Department's efforts to expand services and supports to children with developmental disabilities and their families is to be commended. At the same time, the rate that is proposed at a level of \$20 per hour appears to be unrealistically low for the supports that come under the purview of these regulations.

Based on feedback from agencies currently supporting these children I offer the following comments from agencies already involved in delivering supports for your consideration.

EPSDT services are considered very difficult to provide. The rates are considered to be entirely too low to accommodate the hours of planning that have to go into the supports, not to mention the coordination of their delivery. The rate of \$20/hour doesn't begin to cover the expenses. One provider suggested that the rate of \$25/hour under the autism waiver was a more appropriate level.

Providers must absorb all administrative costs within the EPSDT rate including staff training, time talking with the family about schedules, changing schedules, transportation, activities, etc. It was also noted that delivering this service is very time consuming and requires extensive supervision as many the families require a lot of attention and support. Additionally it was noted that the rate should reflect not only the cost of providing the direct support, but also appropriate levels to pay for fringe benefits and employer taxes.

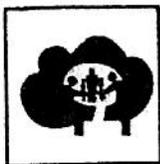
I hope these comments are helpful in finalizing these regulations. It seems unwise to create a program to deliver a much needed service and fail to adequately address the reimbursement requirements to assure the successful fruition of such a well-intentioned program.

Please do not hesitate to contact me should you require additional information.

Sincerely,



Diane McComb
Executive Director



VILLA MARIA

"We Cherish the Divine Within"

2300 Dulaney Valley Road Timonium, Maryland 21093-2799
Voice/TDD (410) 252-4700 Fax (410) 252-3040

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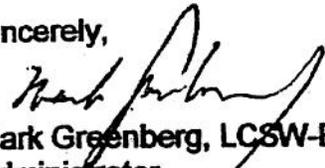
October 24, 2002

Ms. Cathy Surace
Maryland Disability Law Center
1800 N. Charles Street
Suite 400
Baltimore, Maryland 21201

Dear Ms. Surace,

Last week when I ran into you at the Parent Training Meeting you inquired about why Villa Maria was not applying to become a provider of EPSDT One on One Therapeutic Behavioral Aides. Although we recognize that one on one therapeutic behavioral support would be an important and in some cases critical service for the many families we work with, we currently have no plans to add this intervention to our continuum of Community Based Wrap Around Services. Unfortunately, the rate that has been set for this service is only \$20.00 per hour. We are convinced that this service could be an invaluable, temporary support for children and adolescents whose maladaptive behavior puts them at risk of a more structured and restrictive living situation. We are also convinced that working one on one in the home of an adolescent with serious emotional disabilities is a risky proposition. Many of the children we work with exhibit challenging and at times aggressive and sexualized behavior. We would be hesitant to provide this service unless we could deploy skilled and experienced staff with sufficient clinical support and back up. We do not believe that \$20.00 per hour comes close to the cost involved in providing this type of service to the children we work with. The \$20.00 per hour fee would be sufficient to pay the salary (including night shift differential), benefits, transportation costs, training and miscellaneous costs of the one on one behavioral health aide staff. This rate however, does not begin to cover the cost of the supervision, back up coverage, billing costs and other administrative costs (e.g. insurance, cell phone, record keeping, recruitment, payroll etc.) that we would incur. We are aware of the states' budget deficit and realize that it will be some time before meaningful adjustments can be made to the fee for service rates that have been established for any number of critical services. Unfortunately, until an adjustment is made to the fee for one on one behavioral health aides we can not consider bringing up this service for the children we serve who could benefit from the service. I hope this addresses your question if you need any additional information please don't hesitate to let me know.

Sincerely,


Mark Greenberg, LCSW-BCD
Administrator

 **Catholic Charities**

TBS Survey

October 23, 2006

1. Has the TBS service provider supplied adequate staff to provide the services specified in the behavioral health plan?

They are always hiring more people,

2. Did TBS begin in a timely manner after the referral for services was made?

NO
It took almost 4 months

3. Is the number of hours of TBS provided less than what is specified in the behavioral health plan?

YES

4. Have you experienced any breaks in service? If so, why.

YES they have to find a new person to work with my child
First person did not meet child needs,

5. Additional comments:

I believe it is very important to the child & family to have this service and should be available when needed,

Thank you

Lillian