



**On Our Own of Maryland, Inc.**  
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To: The Honorable Boyd K. Rutherford, Lieutenant Governor, State of Maryland  
Chair, Commission to Study Mental and Behavioral Health

**On Our Own of Maryland (OOOMD)** is a statewide peer-operated behavioral health advocacy and education organization. We represent 23 affiliate peer-operated nonprofit organizations which provide peer support services to individuals with mental health and/or substance use disorders in their local jurisdictions. We work with service providers, peers and professional/community organizations to ensure that services and systems are trauma-informed, culturally responsive, and recovery-oriented by reducing stigmatizing practices and expanding consumer involvement in mental health and substance use policy and planning at local, state, and national levels.

### **Our Peer-run Network of Wellness & Recovery Nonprofit Organizations**

Our affiliate network of peer-run Wellness and Recovery Centers have been providing recovery-based, peer support services for more than 25 years. They are funded by the Maryland Behavioral Health Administration and are recognized as part of the continuum of care in the public behavioral health system.

In an average year, our network approximately serves **more than 7000 unduplicated individuals** living with mental health and/or substance use conditions. The population served by the centers has historically been comprised of those experiencing homelessness, the uninsured, and many who refuse formal treatment due to previous adverse experiences with the behavioral health system. Our centers offer **low to no barrier engagement in recovery**. Their services are free and serve anyone who walks in the door needing support. No medical diagnosis or other criteria is required. The peer-run centers that comprise our affiliate network provide services including but not limited to:

- 1-on-1 Peer Support, Group Peer Support, & Self-Advocacy Support
- Wellness Recovery Action Plan (WRAP) classes
- Warmlines
- Crisis De-escalation and Diversion
- MH/SU Treatment Referrals
- Resource Assistance such as: Food Banks, Benefits Application Support & Housing/Employment Assistance, Transportation/ Accompaniment to Court, Medical appointments, etc.
- Training/Advocacy Opportunities and Volunteer Work
- Yoga, Mindfulness, & Art Classes

Our centers **operate on a budget averaging ~\$125,000. They are vastly underfunded to provide the services necessary to meet the needs of those who seek their support.** Many struggle with the cost of keeping their doors open and have limited staffing, often relying on the altruism and dedication of volunteers.

### **The Impact of the COVID-19 Pandemic on our Affiliated Peer-Run Centers**

Now with the COVID-19 pandemic, the recovery and wellness needs of this population have become even more complex due to substantial increases in unemployment, the accompanying financial struggles, isolation and lack of connectivity, limited access to essential resources, and increased barriers to



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receiving treatment. Despite this, our centers have continued to find innovative ways to serve their communities throughout the pandemic.

Some examples of the services our affiliated peer-run centers have been providing during the COVID-19 pandemic include but are not limited to:

- Food Banks
- Warmlines
- 1-on-1 Peer support & Virtual Support Groups
- 'Wellness Checks' to distribute resources to isolated, at-risk members
- Distribution of Digital Technology
- Shower & Laundry Services

Like many, our centers now face even more financial burden resulting from the increased cost of funneling resources to safely operate their centers and keep members safe through COVID-19. The services offered by our network have been vital in supporting and providing resource assistance to the most vulnerable and high-risk communities. Peer services are inexpensive and cost-saving, as they have been shown to decrease the utilization of other costly health care services, which are now needed more than ever. Additionally, these programs have been linked to an increased sense of hope and confidence in one's own ability to bring about positive change in one's life, as well as an improved sense of social support and community. Investing in the future and the sustainability of peer programs has the potential to result in cost-savings for the healthcare system due to the low cost of offering peer services, reduced emergency room service use, and improved engagement in self-care and wellness practices.

However, in order for our centers to continue to serve the community, the 4% increase will be vital to keep up with the cost of social distancing needs, rising operational costs, and minimum wage adjustments.

We are hopeful that the Lieutenant Governor's Commission to Study Mental and Behavioral Health will take a hard look at the indispensable nature of these centers in providing services to Maryland's most vulnerable citizens as they assess the state of the public behavioral health system, and increase their budgets collectively so that they might continue to provide essential, high-quality peer services.

Many thanks,

Michelle Livshin  
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Prince George's  
County

August 20, 2020

Commission to Study Mental and Behavioral Health in Maryland  
c/o Boyd K. Rutherford Lieutenant Governor  
State of Maryland Chair  
Mental and Behavioral Health Commission  
100 State Circle  
Annapolis, MD 21401

Via Email: [mbh.commission@maryland.gov](mailto:mbh.commission@maryland.gov)

Dear Lieutenant Governor Boyd K. Rutherford,

Thank you for your efforts to identify the gaps and problems with the state's current mental and behavioral health systems.

On behalf of NAMI Prince George's County, MD, Inc., I write to strongly recommend that the *Youth and Families Subcommittee* include in its *Caregivers and families* focus area an exploration of **Family Peer Support Services** across the state of Maryland. Emphasis should be placed on how the state can deliver Family Peer Support Services in the most effective and equitable manner. The subcommittee should identify barriers to providing Family Peer Support Services, and determine what the state can do to overcome those obstacles.

Valuable *outcomes*<sup>1</sup> of **Family Peer Support Services** include:

- Family Peer Support programs help parents who have children with special needs find and become reliable allies for each other
- Parent-to-parent support programs are valued by parents and may improve the emotional functioning of parents who have children with disabilities and help them improve their coping skills
- Parents displayed a greater increase in hopefulness and were overwhelmingly satisfied with their experiences
- There is encouraging evidence of reducing child symptoms and improving child functioning as a secondary result of supporting the parent
- Evidence of some benefits to the parents and caregivers including a reduction of stress, improved mental health and well-being, perceived social supports and increased engagement into services

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<sup>1</sup><https://www.nasmhpd.org/sites/default/files/Benefits%20of%20Family%20Peer%20Support%20FIC%20SAMSHA%20Updated.pdf>.

NAMI Prince George's County, MD, Inc.  
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In addition to Family Peer Support Services for parents with children under the age of 18, **Family Peer Support Services are needed for adults/caretakers of adults with serious mental illness (SMI)**. It would be extremely helpful if Family Peer Support Specialists are allowed to be present at the hospital during a mental health crisis to assist with navigating processes. A model for such support can be found by taking note of volunteer rape crisis and domestic violence advocates whose presence in emergency rooms is widely accepted and encouraged.

## Who We Are

NAMI Prince George's County, MD, Inc. (NAMI) is a nonprofit organization established in 1981 and dedicated building better lives for individuals and their families in Prince George's County who are impacted by mental illness through programs of advocacy, education, support and public awareness.

One of the most significant ways we accomplish our mission is by providing *peer support*, outreach and education. At its core, the peer support "approach" assumes that people who have similar experience can relate and can consequently offer more authentic empathy and validation.<sup>2</sup> As a mental health intervention and recovery model, peer support has proven to:<sup>3</sup>

- Decrease hospital admission rates
- Decrease hospital re-admission rates
- Increase hospital discharge rates
- Evoke feelings of empowerment among participants, and
- Improve social support and social functioning

Since its inception, NAMI has worked to eliminate the pervasive stigma of mental illness that causes shame, embarrassment and discrimination that ultimately prevents people from seeking needed treatment and services. We continuously advocate for integrated behavioral healthcare and treatment with the goal of recovery.

NAMI strives to increase public knowledge and understanding of mental health conditions and raise awareness about the critical needs for persons affected by mental health conditions. We encourage community compassion and provide education for knowledge and understanding and peer support to help individuals and their families on the long and difficult journey to wellness and recovery.

Thank you kindly for your consideration.

Sincerely,



JB Moore  
Executive Director

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<sup>2</sup> [file:///C:/Users/gmoor/Downloads/A review of the literature on peer support in ment%20\(1\).pdf](file:///C:/Users/gmoor/Downloads/A%20review%20of%20the%20literature%20on%20peer%20support%20in%20ment%20(1).pdf).

<sup>3</sup> Ibid.

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Thank you for the opportunity to provide comments today. My name is Ellen Weber, and I am Vice President for Health Initiatives at the Legal Action Center. We lead the Maryland Parity Coalition and, in the past, have come before you with recommendations to improve access to substance use disorders (SUD) and mental health (MH) services through strong enforcement of the Mental Health Parity and Addiction Equity Act.

Today, I would like to share the Maryland Parity Coalition's recommendations to make permanent flexible telehealth service delivery for MH and SUD treatment in Medicaid. Thirty-six (36) state-wide organizations have endorsed these recommendations. We have shared our recommendations with State officials and have met with and discussed the recommendations with Maryland Medicaid and the Behavioral Health Administration (BHA).

We commend the State for making MH and SUD services broadly available to patients in their homes and via audio-only communications under the federal and state public health emergencies.

**These practices have given Marylanders access to life-saving treatment without placing themselves, their families, providers and the public at greater risk of exposure and transmission of the virus.** It has allowed for service delivery:

- in communities (both rural and more urban) that have no or limited access to broadband technology; and
- to individuals who cannot afford computers or internet access.

Surveys by the BHA and Maryland's provider associations have demonstrated widespread satisfaction with this mode of service delivery.

**We urge the State to adopt the following practices on a permanent basis with Medicaid reimbursement to ensure maximum access to care.**

1. Allow patients to receive SUD and MH telehealth services in their homes or other locations agreed upon by the patient and provider.
2. Define telehealth, in State law, to include service delivery by audio-only telephonic communications and provide reimbursement for those services on par with in-person services (with a federal Medicaid match). Two states, Colorado and New Hampshire, have done so already.

3. Revise existing telehealth regulations to remove prescriptive and unnecessary technology requirements for audio-visual communications, requiring, more generally, HIPAA compliant technologies.
4. Adopt state licensure requirements to allow a full range of practitioners to deliver care via telehealth on the same basis as in-person services, including Alcohol and Drug Trainees, who provide services under supervision, and paraprofessionals as part of licensed programs.
5. Advocate with federal officials for continuation of flexible prescribing practices for patients with mental illness and opioid use disorders, including initiation of treatment with a controlled substance, and flexible take-home privileges for methadone.

State data has already shown an increase in overdose deaths during the pandemic, and we know that rates of mental health and substance use disorders will increase as a result of the pandemic. We urge the State to take steps now to ensure Marylanders more comprehensive access to care.

Thank you for considering our views and we look forward to working with you.

Ellen Weber

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## Delivery of Mental Health and Substance Use Disorder Treatment Via Telehealth to Aid Maryland's Recovery from COVID-19

### Introduction

In response to the COVID-19 pandemic, Maryland has increased flexibilities for the delivery of telehealth services to ensure Marylanders with mental health (MH) and substance use disorders (SUD) and co-occurring disorders across the State can receive treatment while minimizing the risk of exposure to and transmission of the virus. As the country and State gradually reopen, the safety of Medicaid providers and participants must remain a priority, particularly as the Medicaid system begins to meet the growing need for MH and SUD care. Maryland's providers will be unable to operate at full capacity in community-based settings while the need for social distancing and the use of personal protective equipment (PPE) continues to prevent the spread and resurgence of COVID-19. Medicaid participants, who frequently lack access to private transportation and other resources, should not be placed at greater risk as they access health care. In addition, residents of rural and other communities that experience provider shortages and limited access to broadband service must continue to have access to life-saving health services. All Marylanders, including our most vulnerable residents, must be able to continue to receive MH and SUD services safely and efficiently.

Accordingly, the undersigned 36 members of the Maryland Parity at 10 Coalition and the Maryland Behavioral Health Coalition are calling for emergency action to meet the growing demand for continued flexibility in telehealth requirements for MH and SUD services after the federal and State public health emergency declarations are lifted. These standards should remain in place over the next year, at a minimum, until an effective vaccine is readily available for all residents.

**The Coalition recommends the following telehealth standards and practices in the Medicaid program to ensure safe and comprehensive access to SUD and MH care as Maryland gradually reopens and prepares for subsequent COVID-19 surges.**

1. **Originating sites:** authorize expansion of permissible sites where patients can access telehealth, including patients' homes and additional locations that meet patients' needs;
2. **Distant sites:** authorize reimbursement for telehealth services delivered by provider and paraprofessionals on the same basis as in-person services;
3. **Technology:** authorize reimbursement of additional telehealth technologies to meet the needs of all Medicaid members;
4. **Reimbursement:** continue payment parity standards for telehealth services and remove discriminatory authorization requirements for MH and SUD telehealth services; and
5. **Access to Medication for SUD and MH Treatment:** advocate with federal regulators to extend the exemption of in-person medical examination requirements for treatment initiation and prescription of controlled substances and take-home dose restrictions for methadone.

**Our recommendations are based on the following principles:**

1. **Continuation of Telehealth:** The COVID-19 pandemic requires the continuation of flexible telehealth practices so that high quality MH and SUD care can be delivered safely and without disruption pending the development of a

**EQUAL INSURANCE COVERAGE OF SUBSTANCE USE  
AND MENTAL HEALTH DISORDERS. IT'S THE LAW.**

vaccine. Telehealth flexibilities for MH and SUD care must be equivalent to those for medical/surgical care, consistent with the Mental Health Parity and Addiction Equity Act (Parity Act).

2. **Patient Choice:** Patients have the right to work with their providers to determine the most appropriate service delivery model – in-person services, audio-visual telehealth, telephone calls, or a mix – based on therapeutic considerations and individual needs. Patients must retain the right to refuse the delivery of services via telehealth without risking the loss or withdrawal of program benefits. Service delivery options must be equivalent to those for medical/surgical care, consistent with the Parity Act.
3. **Privacy:** Consumers have the right – and a critical need – for privacy and security protections when accessing SUD and MH care, including adherence to protections for patients receiving SUD treatment under 42 C.F.R. Part 2.
4. **Quality:** Telehealth services must meet the same level of quality required of in-person care.

## Originating Site

### *Background*

The Maryland Medicaid Program requires telehealth services to be delivered to a patient who is located at one of 13 designated originating sites by a provider at a distant site.<sup>1</sup> The State enacted legislation in April 2020 to authorize MH telehealth services to originate in a patient's home and require the Maryland Department of Health (MDH) to apply for an 1115 waiver to implement a pilot program to provide chronic case management services through telehealth regardless of the program participant's location.<sup>2</sup> MDH is also required to study whether SUD services may be provided through telehealth to a patient in their home setting.

During COVID-19, MDH has expanded access to telehealth by relaxing the restrictions on originating sites and providing reimbursement under these circumstances. The State has allowed most telehealth services to originate in "a participant's home or any other secure location as approved by the participant and the provider."<sup>3</sup> Medicaid participants have also been able to utilize telehealth while residing in psychiatric rehabilitation programs (PRP) and SUD residential facilities.<sup>4</sup>

### *Recommendations*

**Maryland Medicaid should expand its designated originating sites to ensure on-going and safe access to SUD and MH services that meet the needs of the State's most vulnerable residents and reimburse for telehealth services at these locations.**

1. The designated originating sites should include a participant's home or any other location as approved by the participant and the provider. The definition of "home" should include shelters, any other location for persons who experience homelessness or lack a permanent residence, and recovery residences. Participants who feel unsafe or lack privacy in their homes should be able to identify an alternative setting with their providers for telehealth services.
2. Designated originating sites should include residential rehabilitation and treatment settings, including PRPs and SUD residential treatment facilities.
3. Maryland should utilize data from this emergency period to satisfy the HB 1208/SB 502 study requirement and conclude that the delivery of SUD telehealth services to patients in their home is appropriate and essential to service delivery on a permanent basis.

<sup>1</sup> COMAR §§ 10.09.49.02, 10.09.49.06(C).

<sup>2</sup> HB 1208/SB 502 (2020). This legislation conditions reimbursement of MH telehealth services originating in a patient's home on state budget limitations.

<sup>3</sup> MDH Guidance COVID-19 #1 (Mar. 12, 2020).

<sup>4</sup> MD Executive Order No. 20-03-20-01 (Mar. 20, 2020); MDH COVID-19 Guidance #4b, #4c (Mar. 21, 2020).

### Justification

It is essential for patients to access telehealth for SUD and MH services from their homes, or wherever they may be located at the time of service delivery. This includes residential treatment settings, where patients and providers may need to physically isolate to reduce the risk of contracting COVID-19, while ensuring access to the full scope of treatment.

As Maryland Medicaid begins to assess whether it will continue to reimburse for the delivery of MH and SUD telehealth services from a patient's home, it should follow Medicare standards that explicitly authorize the home as an originating site for individuals with SUDs for the purpose of substance use disorder treatment.<sup>5</sup> At least 20 states authorized the home to be the originating site for Medicaid telehealth services pre-COVID-19.

Early reports indicate that both patients and providers in Maryland have seen extraordinary benefits from expanding access to SUD and MH telehealth services from homes and other facilities. The [Maryland Addiction Directors Council's survey](#) of over 400 patients found that the majority of respondents were satisfied with the quality of their telehealth services and were able to access care that would not have otherwise been available to them during the pandemic. Likewise, [Community Behavioral Health's survey](#) of more than 4,000 patients found that the vast majority of respondents wished to retain the ability to access telehealth services after the State of Emergency ends and be able to utilize the telehealth option in combination with in-person visits. Seventy percent (70%) of respondents prefer to use telehealth services for at least half of their visits.

Patients have benefited from the economic security associated with not needing to finance transportation to appointments or miss work or arrange childcare to keep appointments. Reducing unnecessary financial barriers to treatment is essential as more families experience unemployment and furloughs and an associated need for MH and SUD services. Health Care for the Homeless has reported that missed appointment rates for behavioral health services have significantly declined since the expansion of telehealth and that practitioners are better able to manage a patient's medications and co-occurring conditions. Other providers have found that it is easier to fill open slots with telehealth, schedule appointments to accommodate patients' work schedules, continue and resume treatment for patients who have moved to a new location, and provide additional language translation services for patients whose primary language is not English. Providers have also been able to get a better sense of a patient's home environment during telehealth visits, including those that do not have a home, such that they can tailor treatment more effectively to meet the patient's needs.

Medicaid members who are experiencing homelessness and those who do not feel safe and secure in their homes have greatly benefited from the opportunity to use telehealth from an alternate location that is identified with their providers. Many individuals who seek behavioral health treatment have a unique and heightened need for privacy and may not feel comfortable using telehealth in their homes where family members can overhear conversations. For patients who are participating in group telehealth sessions, the need for that privacy and security extends to all members of the group as well as the provider and may require service delivery outside of a patient's home when a facility-based site is not accessible.

Finally, the State has sufficient data from this emergency period to determine that SUD services may be safely and effectively provided by telehealth to Medicaid patients in the home. It is unnecessary and redundant to conduct a separate study. Maryland should take the necessary and immediate steps to expand this practice under Medicaid via regulations or a State Plan Amendment to ensure reimbursement.

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<sup>5</sup> 42 C.F.R. § 410.78(b)(3)(xii).

## Provider/Distant Site Recommendations

### *Background*

The State requires providers to be enrolled in Maryland Medicaid and offer services within the scope of their practice to deliver MH and SUD care via telehealth.<sup>6</sup> Within assertive community treatment (ACT) and mobile treatment services (MTS), only psychiatrists and psychiatric nurse practitioners are permitted to serve patients through telehealth.<sup>7</sup> Certified peers or paraprofessionals who work within ACT and MTS programs are not permitted to serve clients via telehealth. This restriction applies in other SUD and MH programs and settings in which certified peers and paraprofessionals may not be reimbursed for telehealth services despite working under supervision in licensed programs and providing the same services in-person.

During COVID-19, the U.S. Department of Health and Human Services issued a broad waiver to allow providers with equivalent licenses in other states to serve Medicaid members across state lines.<sup>8</sup> Maryland received a waiver to relax these requirements, and to streamline provider enrollment in Maryland Medicaid.<sup>9</sup> MDH issued a directive allowing Alcohol and Drug Trainees (ADT) to deliver telehealth services within the scope of their practice and with adequate supervision and appropriate technologies.<sup>10</sup> Maryland also expanded the ability of all licensed ACT and MTS programs to allow the use of telehealth by all team members (licensed and paraprofessional).<sup>11</sup>

### *Recommendations*

**Maryland Medicaid should permit all providers and paraprofessionals who provide in-person services in a licensed Maryland program to continue serving patients via telehealth within the scope of their practice. Professional licensing boards should facilitate the licensure process of all MH and SUD provider applications, including those from out-of-state, to address the shortage of MH and SUD providers and unmet needs in the community.**

1. All providers and paraprofessionals working within a licensed MH or SUD program in Maryland should be reimbursed for providing services via telehealth consistent with reimbursement of those services when delivered in person. In particular, ADTs should continue to be reimbursed for telehealth services.
2. Maryland's health occupation boards should evaluate the impact of licensure flexibility during the pandemic and identify measures that will facilitate the licensure of MH and SUD providers.

### *Justification*

Maryland has a significant shortage of MH and SUD providers, and the Medicaid provider network is inadequate to meet the needs of Medicaid members, particularly those who need language accessible services. To ensure continuity of care, all providers and paraprofessionals working within a licensed MH or SUD program, including ADTs, must be authorized to use telehealth to meet the needs of their patients. Licensed programs have supervisory structures and quality assurance practices in place for in-person service delivery, and the telehealth platform does not alter that structure.

<sup>6</sup> COMAR § 10.09.49.06.

<sup>7</sup> MD Ins. Code § 15-105.2. This law will sunset on September 30, 2021.

<sup>8</sup> Dep't of Health & Human Services, Waiver or Modification of Requirements Under Section 1135 of the Social Security Act (Mar. 13, 2020), <https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx>.

<sup>9</sup> Dep't of Health & Human Services, Section 1135 Waiver Flexibilities – Maryland Coronavirus Disease 2019 (Mar. 26, 2020), <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/87756>.

<sup>10</sup> MDH, Directive and Order Regarding the Board of Professional Counselors and Therapists (Apr. 6, 2020), <https://health.maryland.gov/bopc/Documents/mdhorderbopc1.pdf>.

<sup>11</sup> MDH, Telephone Services Authorized During State of Emergency for Mobile Treatment and ACT Services (Mar. 25, 2020), [https://bha.health.maryland.gov/Documents/Telephone%20Services%20Authorized%20for%20Mobile%20Treatment%20and%20ACT%20032520\(1\)%20\(1\).pdf](https://bha.health.maryland.gov/Documents/Telephone%20Services%20Authorized%20for%20Mobile%20Treatment%20and%20ACT%20032520(1)%20(1).pdf).

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Out-of-state providers who have filled a specific need during the pandemic (e.g. services for college students who have received out-of-state care) should continue to be allowed to serve patients, with appropriate assurances of high-quality care and accountability, during the declared State of Emergency. The Professional Boards should facilitate access to MH and SUD care by adopting measures to ensure prompt licensure of providers.

## Technology

### Background

Maryland Medicaid regulations define telehealth as the delivery of medically necessary somatic or behavioral health services through the use of multimedia communication equipment permitting two-way real-time interactive audio-visual communication between a patient at an originating site and a provider at a distant site.<sup>12</sup> The regulations impose minimum technological requirements regarding the type of camera equipment, audio equipment, bandwidth speed, display monitor size, and transmission length.<sup>13</sup> Providers are required to comply with Maryland privacy laws, HIPAA privacy rules, and 42 C.F.R. Part 2, and ensure that all interactive video technology-assisted communication complies with HIPAA patient privacy and security regulations at the originating site, distant site, and in the transmission process.<sup>14</sup>

These requirements have not been enforced during the pandemic, pursuant to federal and State declarations.<sup>15</sup> The State has authorized the delivery of telehealth through an audio-only telephonic delivery model for MH, SUD, and other medical services, as well as the expansion of remote patient monitoring (RPM) for "all conditions capable of monitoring via RPM."<sup>16</sup>

### Recommendations

**Maryland Medicaid should reimburse for telehealth services that are delivered via all communication technologies that comply with the HIPAA, including audio-only technologies, when patients request such mode of communication and providers implement reasonable safeguards, consistent with HIPAA's privacy rule.**

1. Telehealth should include audio-only services, and Maryland Medicaid should authorize reimbursement when a patient is unable to access audio-visual communications and requests the use of audio-only services, pursuant to HIPAA and 42 C.F.R. Part 2, as applicable.
2. Existing technological requirements for audio-visual telehealth services in COMAR should be updated to allow for reimbursement of any interactive audio or interactive video that complies with the HIPAA security rule.
3. Remote patient monitoring (RPM) for MH and SUD treatment should be reimbursed.
4. Maryland should explore funding and reimbursement options to expand telehealth access across Maryland for secure technology devices, WiFi, broadband, phone minutes, and any other resources that Marylanders may need to access telehealth.

### Justification

Income, race, age, disability and geographical disparities result in limited access to the technology standards that Maryland Medicaid currently requires for telehealth services. Technology, which changes rapidly, should not be a barrier to MH and SUD services. It is vital to continue audio-only telehealth services and to revise Maryland's definition of audio-

<sup>12</sup> COMAR §§ 10.09.49.02, 10.09.49.09(B).

<sup>13</sup> COMAR § 10.09.49.07(B).

<sup>14</sup> COMAR § 10.09.49.08.

<sup>15</sup> Dep't of Health & Human Services, Waiver or Modification of Requirements Under Section 1135 of the Social Security Act (Mar. 13, 2020), <https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx>.

<sup>16</sup> MDH Guidance COVID-19 #4a, #4b, #4c (Mar. 21, 2020); Maryland State Plan Amendment #20-0003 (May 4, 2020), [https://mmcp.health.maryland.gov/Medicaid%20COVID19/Updated%20MD%20SPA%2020-0003%20APPROVAL%205\\_1\\_2020.pdf](https://mmcp.health.maryland.gov/Medicaid%20COVID19/Updated%20MD%20SPA%2020-0003%20APPROVAL%205_1_2020.pdf).

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visual technology to eliminate standards that prevent all Medicaid members from participating because they lack the technology, resources, or experience to access telehealth.

Nothing in Medicaid law prohibits reimbursement of audio-only telehealth; only Medicare law. Outside of telehealth, in 2019, Medicare authorized reimbursement for patient-initiated “virtual check-ins” with providers and practitioners through a range of devices that include telephones.<sup>17</sup> Additionally, nothing in the Social Security Act requires Medicaid to base its definition of telehealth or reimbursement standards on Medicare law. Individual patient considerations and circumstances necessitate the use of telephonic, audio-only telehealth, especially for the State’s most vulnerable populations.

HIPAA permits audio-only telehealth over the phone, as long as providers implement reasonable safeguards under the Privacy Rule, such as conducting telehealth in private settings and adopting safeguards to limit incidental disclosure and use of patient information.<sup>18</sup> HIPAA permits a provider to use personal health information (PHI), including a patient’s phone number, for treatment purposes and does not include voice transmitted via telephone as an electronic transmission subject to the security rule.<sup>19</sup> The State should authorize reimbursement for audio-only telehealth, provide patient education on how to secure personal devices and ensure that conversations are not overheard, and issue guidance for patients and providers on how to verify each other’s identities. Colorado recently passed legislation permitting the use of audio-only telephones for telehealth services in Medicaid when they are used in a HIPAA-compliant manner,<sup>20</sup> and Maryland could follow this example.

Behavioral health providers have found the use of RPM to be extremely beneficial to ensure patients are maintaining their medication regimens and staying on track with their treatment plans. The State’s temporary expansion of telehealth to include all conditions capable of monitoring via RPM, arguably including MH and SUD conditions, demonstrates the value of this service. To the extent Medicaid reimburses RPM for medical conditions but not MH and SUD, it likely violates the federal Parity Act. Maryland should therefore authorize the use of these technologies in MH and SUD settings and seek funding to expand equitable access to them.

Even with the COVID-19 relaxations, there is an ongoing need to minimize the gaps in access to technology that perpetuate health disparities including sufficient broadband, WiFi, and other infrastructure to access telehealth. Low-income residents and many with chronic psychiatric conditions are less likely to have phones with cameras, encryption technology, or minutes to access the audio-only services they might need. Maryland Medicaid should explore reimbursement models, grants, and funding to ensure that members can access these vital resources to bridge the digital divide.

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<sup>17</sup> CMS, Medicare Telemedicine Health Care Provider Fact Sheet (Mar. 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>.

<sup>18</sup> 45 CFR § 164.530; *see also* U.S. Dep’t of Health & Human Services, “Where can health care providers conduct telehealth?” (Mar. 27, 2020), <https://www.hhs.gov/hipaa/for-professionals/faq/3021/where-can-health-care-providers-conduct-telehealth/index.html>. Audio-only telehealth is not subject to the Security Rule, which only governs electronic PHI and does not include voice transmitted via telephone. 45 CFR §§ 160.103, 164.302.

<sup>19</sup> 45 CFR § 164.506(c)(1).

<sup>20</sup> Colo. S.B. 20-212 (2020), <https://leg.colorado.gov/bills/sb20-212>.

## Reimbursement

### Background

Maryland Medicaid reimburses telehealth services in the same manner and at the same rate as in-person services – commonly referred to as “payment parity.”<sup>21</sup> The State regulations do not reference the payment parity requirement, fail to make clear that SUD intensive outpatient and other services may be reimbursed when delivered via telehealth, and explicitly exclude reimbursement for distant site facility costs. Additionally, all MH and SUD telehealth services require prior authorization, while no such limitation exists for medical/surgical services.<sup>22</sup>

The Maryland Health Care Commission has supported the expansion of telehealth technology,<sup>23</sup> but to date, few community-based MH and SUD providers have been awarded funds and may have had limited need to pursue funding previously based on the pre-COVID clinic model of care. In response to the pandemic, additional funding opportunities have become available, including the CARES Act Federal Communication Commission’s COVID-19 Telehealth Program.<sup>24</sup>

### Recommendations

**Maryland Medicaid should ensure that providers are reimbursed for the full range of MH and SUD services at the same level as in-person services and eliminate any coverage barriers that limit access to MH and SUD care.**

1. Reimbursement rules should explicitly require payment parity for all providers of telehealth services, consistent with in-person services, and clarify that all SUD and MH services may be reimbursed under telehealth, consistent with therapeutic practice and patient needs.
2. MH and SUD services delivered via telehealth should not be subject to more stringent prior authorization requirements than medical/surgical services, consistent with the Parity Act.
3. Maryland should explore opportunities to provide additional grants and sustained reimbursement to Medicaid providers seeking to invest in telehealth technologies that satisfy the HIPAA security rules and expand patient access to mobile devices, smartphones and RPM equipment.

### Justification

Payment parity for telehealth services is essential to ensure that MH and SUD providers, including federally qualified health centers, can sustain services at a time when demand is expected to increase. MH and SUD services provided via telehealth are directly equivalent to the services being provided in-person, and the costs associated with providing those services – salaries for practitioners and administrative staff, program overhead, and facility costs – remain the same. At least 25 other states require payment parity for telehealth services, and three of which – Colorado, Kentucky, and Nebraska – require the reimbursement of telehealth services to be “at a minimum” the equivalent of in-person services.

Providers bear significant costs to purchase and maintain HIPAA-compliant telehealth technology and train providers and patients to use these platforms. Even with reimbursement parity, telehealth saves money across the health system, as it increases access to MH and SUD services, prevents acute episodes, and avoids reliance on higher cost treatment in emergency rooms and hospitals. Identification of covered telehealth services and reimbursement standards will lend certainty to the care delivery model and encourage providers to invest in telehealth.

<sup>21</sup> COMAR § 10.09.49.09(A); MHCC, Reimbursement for Telehealth Services (Mar. 2019),

[https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT\\_Telehealth\\_Reimbursement\\_Flyer\\_20200330.pdf](https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Telehealth_Reimbursement_Flyer_20200330.pdf).

<sup>22</sup> COMAR § 10.09.49.09(E)(4).

<sup>23</sup> Maryland Health Care Commission, Health Information Technology, Telehealth (updated Apr. 30, 2020),

[https://mhcc.maryland.gov/mhcc/pages/hit/hit\\_telemedicine/hit\\_telemedicine.aspx](https://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/hit_telemedicine.aspx).

<sup>24</sup> Federal Communications Commission, COVID-19 Telehealth Program (updated May 20, 2020), <https://www.fcc.gov/covid-19-telehealth-program>.

The Parity Act explicitly prohibits Maryland Medicaid from imposing non-quantitative treatment limitations (NQTL), including prior authorization, to MH and SUD benefits that are more restrictive than those for medical/surgical benefits.<sup>25</sup> The imposition of prior authorizations for all MH and SUD telehealth services, but not all medical/surgical telehealth services, violates the Parity Act and should be removed immediately.

### Medications for Substance Use Disorders and Mental Health Conditions – Induction and Administration

#### Background

Federal laws and regulations govern how providers may initiate and administer medications for opioid use disorders (MOUD) and controlled substances for patients with mental health conditions. An in-person physical exam is required before a provider may initiate MOUD in an opioid treatment program (OTP)<sup>26</sup> or other office-based settings and to prescribe a controlled substance for mental illness.

During COVID-19, the Substance Abuse and Mental Health Services Administration (SAMHSA) has exempted OTPs from the requirement to perform an in-person physical evaluation before prescribing buprenorphine to a new patient, assuming an adequate evaluation of the patient can be accomplished via telehealth, but has continued to require an in-patient examination to initiate methadone treatment.<sup>27</sup> SAMHSA also issued guidance allowing greater flexibility around take-home doses of methadone for patients who are deemed stable by their treatment provider.<sup>28</sup> Finally, the Drug Enforcement Administration (DEA) has lifted the Controlled Substances Act requirement<sup>29</sup> for an in-person medical evaluation of patients prior to prescribing a controlled substance.<sup>30</sup>

#### Recommendations

**Maryland should request that the federal government continue to authorize the initiation of buprenorphine treatment and prescription of a controlled substance via telehealth and permit the initiation of MOUD treatment via telehealth within an OTP, along with continued flexibility for take-home medication and reimbursement for medication delivery programs.**

1. Maryland should advocate for an extension of the exemption for the in-person examination requirement before initiating MOUD treatment and treatment with controlled substances for MH conditions.
2. Maryland should advocate for the continued flexibility of take-home doses of MOUD to reduce in-person encounters for patients who are deemed stable.
3. Maryland should reimburse SUD providers and programs to deliver MOUD directly to patients to minimize the risks of transmitting COVID-19.

<sup>25</sup> 42 C.F.R. §§ 438.910(d), 440.395(b)(4), 457.496(d)(4)-(5).

<sup>26</sup> 21 U.S.C. 829(e); 42 C.F.R. § 8.12(f)(2).

<sup>27</sup> SAMHSA, FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency (updated Apr. 21, 2020), <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf>.

<sup>28</sup> SAMHSA, Opioid Treatment Program (OTP) Guidance (updated Mar. 19, 2020), <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>.

<sup>29</sup> 21 U.S.C. § 829(e).

<sup>30</sup> DEA, How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency, (March 31, 2020), [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-023\)\(DEA075\)Decision\\_Tree\\_\(Final\)\\_33120\\_2007.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf).

Telehealth MH & SUD Services to Aid MD's Recovery from COVID-19

July 14, 2020

Justification

As overdose deaths increase in Maryland,<sup>31</sup> effective and safe access to OTP services and other providers of MOUD is essential. OTPs and other programs will be unable to operate at full capacity while social distancing and the use of PPE is required to conduct in-person examinations to initiate methadone treatment and dispense medication. To ease the burden on providers and reduce risk to both patients and providers, the State should urge SAMHSA and the DEA to extend the exemption for the in-person physical examination requirement and continue to allow for greater flexibility in take-home medication standards. In addition, OTPs should be permitted to initiate methadone treatment through telehealth by allowing examinations to be conducted on-site with the patient and provider using telehealth communications, such as a tablet. Finally, for patients who are not eligible for extended take-home medication, the State should reimburse programs for expanded delivery programs to protect both patients and staff, such as the delivery program supported by Behavioral Health Systems Baltimore. Similarly, the State should urge the DEA to extend the exemption for the in-person examination requirement for the initiation of treatment and prescription of a controlled substance to patients with mental illnesses.

Advocates for Children and Youth  
Arundel Lodge  
Baltimore City Substance Use Disorder Directorate  
Baltimore Crisis Response, Inc.  
Brain Injury Association of Maryland  
Catholic Charities of Baltimore  
Community Behavioral Health Association of Maryland  
Cornerstone Montgomery  
Eastern Shore Behavioral Health Coalition  
Greater Washington Society for Clinical Social Work  
Health Care for the Homeless - Baltimore and Maryland  
Healthy Harford  
Horizon Foundation of Howard County  
Institutes for Behavior Resources  
Key Point Health Services  
Legal Action Center  
Licensed Clinical Professional Counselors of Maryland  
Maryland Addiction Directors Council  
Maryland Association for the Treatment of Opioid Dependence

Maryland Association of Behavioral Health Authorities  
Maryland Clinical Social Work Coalition  
Maryland Coalition of Families  
Maryland Coalition on Mental Health and Aging  
Maryland-DC Society of Addiction Medicine  
Maryland Heroin Awareness Advocates  
Maryland Psychiatric Society  
Maryland Rural Health Association  
MedChi, The Maryland State Medical Society  
Mental Health Association of Frederick County  
Mental Health Association of Maryland  
Mid-Atlantic Association of Community Health Centers  
Mid Shore Behavioral Health Coalition  
National Alliance of Mental Illness - Maryland  
National Council on Alcoholism and Drug Dependence of Maryland  
Save Our Children  
Springboard Community Services

Thank you for your consideration of our recommendations. We look forward to working with Maryland Medicaid to ensure high-quality MH and SUD services to Marylanders as the State reopens and continues delivery of care and works to avoid a deadly resurgence of COVID-19 among our most vulnerable residents and treatment providers. Please contact Ellen Weber ([eweber@lac.org](mailto:eweber@lac.org)) and Deb Steinberg ([dsteinberg@lac.org](mailto:dsteinberg@lac.org)) at the Legal Action Center with any questions.

<sup>31</sup> Before It's Too Late, "Opioid Operational Command Center, Department of Health Release First-Quarter Opioid Data for 2020" (June 10, 2020), <https://beforeitstoolate.maryland.gov/opioid-operational-command-center-department-of-health-release-first-quarter-opioid-data-for-2020/>.



#4

Written Testimony for the Commission to Study Mental and Behavioral Health in Maryland

Virtual Meeting: August 25, 2020

From: Kamala Via

**Topic: Request that Commission Recommend Maryland apply for the IMD Exclusion Medicaid Waiver for Mental Illness.**

Dear MBH Commission:

Please accept this letter as written testimony in support of Maryland applying for the IMD Exclusion Medicaid Waiver for Mental Illness.

As a mental health professional working in a busy emergency departments in Baltimore, I have personally witnessed the delays our patients experience waiting for available psychiatric inpatient placement. There are significant and extended wait times for geriatric placements and for patients also experiencing neuro developmental delays.

I respectfully request that the Commission apply for this waiver to benefit our patients requiring more extensive mental health treatment.

Best regards,  
Kamala Via, DNP, CRNP-PMH



Written Comments for the Commission to Study Mental and Behavioral Health in Maryland  
Virtual Meeting: August 25, 2020

From: Evelyn Burton, Advocacy Chair

Maryland Chapter of Schizophrenia and Related Disorders Alliance of America (SARDAA).

**Topic: Request that Commission consider recommendation that Maryland apply for the IMD Exclusion Medicaid Waiver for Mental Illness.**

The Schizophrenia and Related Disorders Alliance of America (SARDAA) is a grassroots non-profit organization promoting improvement in lives affected by serious mental illnesses involving psychosis through support, education, collaboration, and advocacy.

The Maryland Chapter of SARDAA requests that the Commission consider recommending that the state administration apply to the federal Centers for Medicare and Medicaid Services (CMS) for the Medicaid IMD Exclusion Waiver for Mental Illness.

**CURRENT SITUATION:** Under Medicaid law the IMD Exclusion prohibits Medicaid payments for Medicaid individuals ages 21-64 to psychiatric hospitals with over 16 beds. This includes hospitals in Maryland such as Sheppard Pratt and Brook Lane. There is one current exception that Medicaid will pay for 15 days per month for these Medicaid individuals in a Managed Care Program. This restrictive rule on hospitalization which does not take into account medical necessity criteria, applies only to individuals with mental illness and is highly discriminatory.

Maryland is currently a capped amount of state funds to pay the Maryland IMD hospitals to care for patients that fall under the Medicaid IMD Exclusion rule.

**OPORTUNITY FOR CHANGE.** In November of 2018, CMS announced that states could apply for a new IMD Exclusion Waiver for Mental Illness to provide broader Medicaid coverage for those age 21-64 in an IMD. It allows for coverage in an IMD hospital if the average state-wide stay is under 30 days. It also requires the state to enhance outpatient services and show that the waiver is budget neutral to Medicaid. So far 4 states have been approved.

**Although in the past Maryland successfully applied for a similar IMD Exclusion Waiver for Substance Abuse, it has NOT applied for the IMD Exclusion Waiver for Mental Illness.**

Unlike the psychiatric units in general medical hospitals, IMD hospitals have specialized units designed to treat severe psychosis which may take a longer hospital stay to stabilize. They also have specialized units for hard to serve individuals which the psychiatric units of General Hospitals often refuse to admit. This includes dual diagnosis individuals with mental illness and developmental disabilities and eating disorders as well as involuntary patients with a history of violence.

**MARYLAND IS LEAVING MONEY ON THE TABLE.** Under the IMD Exclusion Waiver, Maryland would only pay 50% of the IMD hospital cost rather than the 100% it is currently paying for patients under the Exclusion and the federal government would pay the other 50%. In addition, significant hospital expenditure reductions could be expected by preventing recurrent

hospitalizations and ER visits due to the ability of the IMD hospital to treat according to medical necessity and achieve long lasting stability.

Our family members are frequently confronted with psychiatric crises that are not resolved by the average very short stays of less than a week in the psychiatric units of general hospitals for psychotic illnesses such as schizophrenia and bipolar disorder. This is a major contributor to the flood of people with mental illness into our jails and prisons, as well as resulting in homelessness, violence, and suicide. The IMD Exclusion Waiver could help address this tragedy.

Especially during this time of state budget shortfalls, now is the time to take advantage of Federal funds and promote treatment that reduces expensive repeat hospitalizations by applying for the Medicaid IMD Exclusion Waiver for Mental Illness.

Below is the CMS announcement of opportunity to apply for the IMD exclusion waiver for mental illness.

Press release

## CMS Announces New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services

Nov 13, 2018

- [Initiatives](#)
- [Medicaid & CHIP](#)
- [Opioids](#)

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### **CMS Announces New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services**

*CMS letter to State Medicaid Directors outlines new opportunities for states to receive payment for residential treatment services*

Today, the Centers for Medicare & Medicaid Services (CMS) sent a letter to State Medicaid Directors that outlines both existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The letter includes a new

opportunity for states to receive authority to pay for short-term residential treatment services in an institution for mental disease (IMD) for these patients. CMS believes these opportunities offer states the flexibility to make significant improvements on access to quality behavioral health care.

Medicaid is the single largest payer of behavioral health services, including mental health and substance use services in the U.S. By one estimate, more than a quarter of adults with a serious mental illness rely on Medicaid. Approximately 10.4 million adults in the United States had an SMI in 2016, but only 65 percent received mental health services in that year. Serious mental health conditions can have detrimental impacts on the lives of individuals with SMI or SED and their families and caregivers. Since these conditions often arise in adolescence or early adulthood and often go untreated for many years, individuals with SMI or SED are less likely to finish high school and attain higher education, disrupting education and employment goals.

"More treatment options for serious mental illness are needed, and that includes more inpatient and residential options. As with the SUD waivers, we will strongly emphasize that inpatient treatment is just one part of what needs to be a complete continuum of care, and participating states will be expected to take action to improve community-based mental health care," said Health and Human Services Secretary Alex Azar. "There are effective methods for treating the seriously mentally ill in the outpatient setting, which have a strong track record of success and which this administration supports. We can support both inpatient and outpatient investments at the same time. Both tools are necessary, and both are too hard to access today."

CMS currently offers states the flexibility to pursue similar demonstration projects under Section 1115 (a) of the Social Security Act, regarding substance use disorders (SUDs), including opioid use disorder. To date, CMS has approved this authority in 17 states, where it is already improving outcomes for beneficiaries. For example, early results in Virginia show a 39 percent decrease in opioid-related emergency room visits, and a 31 percent decrease in substance-use related ER visits overall after implementation of the demonstration. With this new opportunity, CMS will be able to offer a pathway forward to the 12 states who have already expressed interest in expanding access to community and residential treatment services for the full continuum of mental health and substance use disorders. About a quarter of individuals with SMI have a co-occurring SUD.

States participating in the SMI/SED demonstration opportunity will be expected to commit to taking a number of actions to improve community-based mental health care. These commitments to improving community-based care are linked to a set of goals for the SMI/SED demonstration opportunity and will include actions or milestones to ensure good quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI or SED in treatment as soon as possible. States are encouraged to build on the opportunities

for innovative service delivery reforms discussed in the first part of this letter and summarized below in order to achieve these milestones and goals.

Through this demonstration opportunity, federal Medicaid reimbursement for services will be limited to beneficiaries who are short-term residents in IMDs primarily to receive mental health treatment. CMS will not approve a demonstration project unless the project is expected to be budget neutral to the federal government.

States will also be expected to report information detailing actions taken to achieve the milestones and goals of these demonstrations as well as data and performance measures identified by CMS as key indicators of progress toward meeting the goals of this initiative.

In addition to the 1115 demonstration opportunity the letter also describes strategies under existing authorities to support innovative service delivery systems for adults with SMI and children with SED, that address the following issues:

- Earlier identification and engagement in treatment, including improved data-sharing between schools, hospitals, primary care, criminal justice, and specialized mental health providers to improve communications;
- Integration of mental health care and primary care that can help ensure that individuals with SMI or SED are identified earlier and connected with the appropriate treatment sooner;
- Improved access to services for patients across the continuum of care including crisis stabilization services and support to help transition from acute care back into their communities;
- Better care coordination and transitions to community-based care; and
- Increased access to evidence-based services that address social risk factors including services designed to help individuals with SMI or SED maintain a job or stay in school.

CMS is announcing this new demonstration opportunity following the publication of the [Medicaid Managed Care proposed rule](#). States identified key concerns in the 2016 final rules limitation regarding 15-day length of stay for managed care beneficiaries in an IMD. CMS did not propose any changes to this requirement at this time; however, CMS is asking for comment from states for data that could support a revision to this policy. Meanwhile, this new demonstration opportunity will give interested states the ability to seek federal authority to have greater flexibility to pay for residential treatment services in an IMD as part of broader delivery system improvements.

For more information, please visit: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

#6

Testimony re IMD Waiver

Written Testimony for the Commission to Study Mental and Behavioral Health in Maryland

Virtual Meeting: August 25, 2020

From: Mary Ellen Moran

TOPIC: Request that Commission Recommend Maryland Apply for the IMD Exclusion Medicaid Waiver for Mental Illness.

I am Mary Ellen Moran, a parent of an adult child who has schizophrenia. When he was 20 he was hospitalized at the Sheppard Pratt Hospital, an IMD psychiatric hospital. He had a major episode of psychosis and it took six weeks for him to become stable enough to be discharged. There has been no need for subsequent hospitalizations.

Because individuals with mental illness need varying numbers of days in inpatient treatment, applying for and receiving the Waiver would make it possible for patients to become stable before discharge. Medical necessity, not a specific number of days, should determine the duration of inpatient treatment.

The Federal 50% IMD co-payment would save the State millions of dollars in current hospital stays, as well as decreases in subsequent admissions and ER visits because of appropriate stabilization treatment.

For reasons that include the above, it is requested that the Commission recommend that the State apply for the IMD Exclusion Medicaid Waiver for Mental Illness.

Your consideration of my request is appreciated.



Virtual Meeting: August 25, 2020

From: Rayetta Michael

**Topic: Request that Commission Recommend Maryland apply for the IMD Exclusion Medicaid Waiver for Mental Illness.**

Hi my name is Rayetta Michael. I am co-founder of Help in the Home, LLC an in home care agency that specializes in supporting people with Severe Mental Illness.

This is a request for the Commission to RECOMMEND the state apply for the IMD Medicaid Waiver for Mental Illness

Over the past 20 years, we've seen the average length of hospital stays decrease from 21 days to currently 5-7 with 10 being a lengthy stay. The result of this is we are looking to hospitalization as TRIAGE for emergency stabilization not treatment. Often, the emergency stabilization is not true stabilization and our clients end up back in the hospital within a few weeks. When I learned there is FREE MONEY from the federal government that can be used to improve the inpatient care desperately needed by those with SEVERE MENTAL ILLNESS, I made plans to speak to you today.

First, let me tell you about "Nancy." After being stable on medications for 4 years, completing courses at Montgomery College, working as a waitress and moving from a supported living community into her own apartment. She stopped taking her medication and started smoking pot with a few drinks. Her illness consumed her within a short period of time. She was hospitalized for less than two weeks and discharged to a crisis bed. There within 3 days she left treatment "choosing" to live on the streets in a psychotic state. If she were able to stay in the hospital until truly being stabilized the outcome would have been different.

This FREE MONEY would allow IMD hospital treatment to be based on medical necessity rather an arbitrary day limit. Consequently, a person would have better stabilization and successful community living after treatment for a medically needed length of time. Furthermore: hospital stays long enough to provide stabilization will reduce ER use, suicide, violence, homelessness, criminalization, and related costs to state and local governments. -- This same "Nancy" ended up in the criminal justice system for trespassing. Her illness so severe the jail became her treatment provider.

It seems like common sense to put the time and effort into applying for this waiver as it would save the State many millions of dollars by receiving the federal 50% hospital payment and decreased readmissions and ER visits. To me this is FREE MONEY that could be used to ensure the Financial stability for Maryland IMD's which are unique in providing many specialized treatment units such as for treatment resistant psychosis, eating disorders and dual diagnosis of mental illness with developmental disabilities.



Written Testimony for the Commission to Study Mental and Behavioral Health in Maryland

Virtual Meeting: August 25, 2020

From: Shannon Harris

Topic: Request that Commission Recommend Maryland apply for the IMD Exclusion Medicaid Waiver for Mental Illness.

I am a professional who has been working in the mental health field for more than 12 years. During my time in this field I have observed countless families suffer as a result of insufficient lengths of stay and lack of specialized care for mental health treatment. Therefore, I request that the Commission recommend that Maryland apply for the IMD Medicaid Waiver for Mental Illness.

I work in mental health outreach and I have received countless phone calls over the years from families desperately seeking longer term stabilization for their loved ones while they are being "stabilized" at an inpatient hospital because they know that the length of stay provided by the hospital will not be enough to stabilize them. I can remember one family specifically, an uncle, trying to help his nephew who ultimately ended up committing suicide shortly after his release from inpatient stabilization.

Lengths of stay should be dictated by necessity, on an individualized, case by case basis by a mental health professional. Arbitrary assignments of length of stay are ineffective and have serious and sometimes fatal consequences for those suffering from mental illness. The IMD Medicaid Waiver for Mental Illness would be a step in the right direction to help those with mental illness receive a length of stay sufficient enough to stabilize them and prepare them for the next appropriate level of care.

Sincerely,

Shannon Harris



HELP  
in the  
HOME

Personalized Care through  
Support and Community

**Shannon Harris, MBA** *Outreach Representative*



August 25, 2020

Testimony to Recommend IMD Exclusion Medicaid Waiver for Mental Illness

My name is Rita Tonner, and I am the parent of a son who had a serious mental illness and substance abuse. He died in 2015 of a drug overdose.

I am requesting that the Commission recommend that Maryland apply for the IMD Medicaid waiver for mental illness.

There is a pressing need for extended lengths of stay in specialized treatment facilities, especially for individuals with a dual diagnosis. My son was regularly hospitalized for medication evaluation, depression, psychosis, relapse due to substance abuse, or overdose of a psychiatric medication. His discharges were often to shelters or back to the space he shared in the basement of a house. He also experienced long waits (sometimes 2-3 days) in ERs waiting for an available bed in a hospital psychiatric unit. He once had an extended stay at a local facility, but there was no transitional therapeutic housing available after his discharge.

The bottom line- He was never able to be effectively treated for his dual diagnosis.

The current IMD Exclusion policy is discriminatory against people with mental illness.

Applying for the Medicaid IMD waiver would benefit Maryland:

- A. Allows IMD hospital treatment based on medical necessity
- B. Improves community transition and success following treatment
- C. Increases financial stability for unique facilities that provide treatment for dual diagnosis of mental illness and substance abuse
- D. Waiver saves the state money due to a 50% federal hospital payment and hopefully decreased readmissions and resulting ER visits
- E. Hospital stays that are longer and more effective reduce ER use, suicide, homelessness, and other adverse effects and costs to state and local government.



Written Testimony for the Commission to Study Mental and Behavioral Health in  
Maryland, Subcommittee Public Safety/Judicial System

My name is Kathleen Smith, I am a resident of Charles County MD. I am a mother of a adult Son who has severe mental illness, developmental disabilities, including Pervasive Development which falls under the umbrella of Autism Spectrum.

As my son grew older his mental illness worsened and his behaviors of rational thought patterns deteriorated at an alarming rate. His inability control his action, his rising level of oddness, suicidal tendencies and destructive behaviors toward himself, his family and society was led us to looking for assistance through the Maryland Emergency Evaluation Petition System and Involuntary Admission process in order to obtain swift medical treatment before tragedy occurred We operated for many years in crisis mode moving fro one episode to another, but did not have much success with the current narrow interpretation of danger standard.

Since 2007 I have repetitively advocated for treatment for my son due to his lack of insight of his own illness. During Covid my son started to deteriorate again and unfortunately the local Sheriffs were called to my home where as my son resides with me. Fortunately the Sheriffs were able to deescalate the situation that was becoming dangerous of potential physical harm to myself and ultimately could have destroyed my sons future to possible re-incarceration.

Upon speaking with the Deputies, I informed them of the lower ineffective dosage of his medication and requested to have them take him to the local hospital for treatment. They denied that request because and I will quote " He isn't suicidal" When they further spoke with my son they explained to him that his parents had a right to being safe in their home and that a protective order could remove him from the home. They asked him what would he do if that occurred. My son stated " I'll go live in the woods in a tent". Now mind you, he had no money for food or a tent in order to survive and all homeless shelters were closed due to Covid.

Maryland statue for involuntary Evaluation and Treatment law needs to be revised should defined as " Present a danger" as subsequent harm to the ill individual, to family and to society and the inability to recognize their own deterioration and the ability to care for their own basic survival needs .



Maryland Commission to Study Mental and Behavioral Health,  
Subcommittee on Public Safety/Judicial System  
Comments from Marilyn Martin, Calvert County, Solomons, MD

My 37-year-old son has severe schizophrenia. He now lives with his father in Montgomery County, MD.

His first psychosis occurred in 2008 when he was 24 years old. Over the past decade, I have been unable to obtain **timely treatment for him by involuntary emergency evaluation because too many community psychiatrists, police and judges have interpreted the standard to mean imminent danger of bodily harm with no consideration given to how delusional or disabled he was at the time.** When left to further deteriorate, people with these neurological disorders can indeed become physically dangerous, most often toward their own family members, who are full-time caregivers.

Just to cite three of our many examples, from the earliest to the most recent in 2016:

By 2009 he refused to take medication, and he did not believe he was ill. When his delusions included a threat to kill someone, I petitioned the court for an emergency evaluation. The judge denied it for lack of "immediacy," although the law no longer stated that imminent danger was required.

In April 2013, my son became so belligerent that I was afraid. His psychiatrist failed to petition for emergency evaluation. Two months later, a neighbor reported threats to the police, who also failed to petition, although finally the doctor did so.

In January 2016, he was visiting me and my husband in Chesapeake Beach. During my drive to return him to his dad's, I grew increasingly anxious about his behavior. Once I returned home, I e-mailed and faxed my concerns to his clinic director and to his provider that I felt endangered by his current behavior. I asked them to get him off the medication that was failing him and to please return to the previous one that worked. I heard nothing from them. When my son called me in February to request another visit, I hoped that he had received proper treatment. He had not, and he was even more dangerous. I was unable to convince him the next day that it was time to leave to return to his dad's. While there, he came in for dinner and picked up my 70-year-old husband by his neck. He kept pounding his fist into my husband's head. When I tried to intervene, my son pushed me into a wall. This episode finally ended with my dialing 911. We were lucky that an officer trained in de-escalation arrived. All too often, that is not the case. The officer took my son to our local hospital, and from there, several days later, to a bed in Montgomery County for treatment.

A broadly interpreted standard leaves too many people in potential danger: the caregivers (family), the disabled people in psychosis, the police, and even the public.

