Draft Meeting Summary
Residential Treatment Center Work Group Meeting
Monday, February 5, 2024
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees

Claudette Bernstein, M.D.
Ezra Buchdahl
Heather Dewey
Sarah Fegan
Bryon Fracchia
Mary Gable
Angela Gray
Shannon Hall
Shawn Lattanzio
Oksana Likova
Tammy Loewe
Jennifer Maehr, M.D.
Ryan Moran
Bryan Mroz
Drew Pate, M.D.
Shelby Schestag
Tennille Thomas
Elizabeth White

Other Attendees

Cathy Baker
Michael Dunphy
Brooke Fox
Catherine Gray
Marie Liddick
Steven Nguyen
Heather Rini
Stephanie Trice
Warren Waters

MHCC Staff Attendees

Teresa Brown
Eliot Burkom
Eileen Fleck
Jeanne-Marie Gawal
Katie Neral
Uzoma Nwachukwu
Ben Steffen

Introduction

Eileen Fleck extended a warm welcome to the online workgroup participants and introduced those attending in-person: Katie Neral, Jeanne-Marie Gawal, and Oksana Likova. Due to technical delays, formal introductions for online attendees were omitted. Ms. Fleck conveyed her appreciation for everyone's patience and then proceeded with the meeting.

Process of Developing Revised Regulations and Timeline

Ms. Fleck explained that there will likely be three meetings of the work group; additional meetings can be scheduled if needed. MHCC staff will then prepare draft regulations and post them for informal comments. Typically, staff allow three to four weeks for public comments. Staff will then consider additional changes before presenting draft proposed regulations to the Commission.

Ms. Fleck explained that it takes approximately five months from approval of proposed regulations to the adoption of final regulations. She noted that the work group meetings may be concluded by June with two additional meetings held before then. She added that the primary focus of updating these regulations is to streamline the Certificate of Need (CON) process and account for changes that have occurred over time.

Questions / Feedback on RTC White Paper

Katie Neral explained that the White Paper on residential treatment centers (RTCs) included in the meeting materials is currently in draft form, and she invited questions, comments, and additional feedback from the group.

Bryan Mroz, Deputy Secretary of Operations for the Maryland Department of Health, described his background and expressed appreciation for the thoroughness of the White Paper. He also commented that the White Paper did not include information on the nature of the infrastructure problems. He explained that John L. Gildner RICA has a very open and porous campus. The school is operated by Montgomery County and the policy is for doors not to be locked. This limits the children who can go to that location. There have also been many children absent without leave (AWOL). He noted that when RTCs were first established they were designed to be integrated with the community.

Mr. Mroz further commented on a project to build 48 beds at RICA Baltimore, which is still about ten years away and inquired about the status of a cottage at John L. Gildner RICA. Ms. Neral explained that the license for the facility has not changed. She apologized if there was any confusion about the number of beds available for the FFC population[1], explaining that some beds were not open when they were surveyed by MHCC. Mr. Mroz confirmed that they have opened six beds for the FFC population and are in the process of opening six more RTC beds for high-

[1] The FFC population refers to children who require residential juvenile competency attainment services, education, case management, and other related services in a safe and caring environment. These children are not served in RTC beds; no therapeutic services are provided, only the care and treatment needed.

intensity youth. Although this does not change the total number of licensed beds, these renovations are designed to accommodate complex or more aggressive children.

Heather Dewey inquired about the expected timeline for processing a request submitted by a provider, specifically the Board of Childcare's RTC project. Ms. Fleck explained that a change in statute requires staff to process the CON applications within a certain timeline. Once an application is complete and docketed, a decision must be issued within 120 days, or it will be automatically approved. This applies to RTC applications, but it does not apply to all CON applications. Ms. Fleck also noted that the time it takes to docket an application varies. New regulations specify how many rounds of questions staff can ask. The goal is to have one round of questions to get all the necessary information. The time it takes for staff to review an application also varies based on the completeness of the application and the applicant's willingness to provide requested information. While the timeframe to review an application can vary, it is not expected to drag on for a year; six months may be a more realistic expectation. Applicants have the option to meet with staff for a pre-application conference to obtain help navigating the CON process.

Mr. Mroz commented that the impact of throughput should be discussed in the White Paper. It is not just the need for more RTC space that is relevant, but also the availability of group home spaces and community resources for patients to transition out of RTCs. Focusing on how the flow of patients in and out of RTCs has changed over time and how it impacts the capacity in RTCs should be discussed in the White Paper. Ms. Fleck agreed. Jennifer Maehr, M.D., agreed, noting that a child's length of stay in an RTC may be longer, if the child cannot transition to another place.

Dr. Maehr commented that there is a growing need for RTCs to handle adolescents with opiate use disorder and substance use issues, given the rising problem of fentanyl and opiates in the District of Columbia metropolitan area. Adolescents with both significant mental health issues and substance use disorders, including those on medication for opiate use disorder, face barriers when accessing RTCs. The question is whether RTCs can adapt to cater to these complex cases. Some organizations, such as Sheppard Pratt and RICA Rockville, have managed medications for opiate use disorder among teenagers. She suggested addressing what role RTCs should play in helping the State address youth with mental health issues and opiate use disorders in the White Paper.

Ms. Fleck asked if there is data available that allows RTCs to provide insights regarding how these issues have changed over time. She then asked if anyone had suggestions for future data collection and tracking. Dr. Maehr suggested looking at data on denials to an RTC. She emphasized the importance of understanding the reasons behind the exclusion of youths from RTCs, to inform the development of more effective regulations. She mentioned that from her perspective the population has changed in the past five years, and there has been an increase in youth with eating disorders in the past three years.

Ms. Dewey asked if CRISP data could be used to get information from high intensity utilizers in emergency departments and inpatient programs including their diagnosis regardless of whether they are admitted to an RTC. Ms. Neral responded that it is a good suggestion to consider data from emergency department visits. Mr. Mroz noted that there is an interagency work group that tracks data on a weekly basis for hospital overstays, including those ready for discharge, those

waiting in an emergency room, those waiting to get into an RTC, and those ready for discharge who do not have an appropriate place to go. Ms. Fleck asked if the data can be shared to incorporate it in the White Paper and how far back the data is available.

Mr. Mroz responded that the interagency committee was established nearly two years ago and despite difficulties in data collection, efforts have been made to enhance data collection procedures, but still do not capture 100 percent of the relevant information. Currently, the Committee tracks around 30 to 50 children per week within the specified group, utilizing a highly detailed approach. They carefully document every aspect of the youth's situation, including diagnoses, home-related challenges preventing their departure, and behaviors observed in the units. This detailed tracking is crucial for State agencies like the Department of Juvenile Services (DJS), Department of Human Services (DHS), and the Maryland Department of Health (including the Developmental Disabilities Administration and the Behavioral Health Administration) to assist in arranging suitable placements. He stated that sharing raw numbers is fine, but he would need to consider what details could be shared, while still protecting patient privacy.

Alyssa Lord suggested the White Paper include information regarding the current Voluntary Placement Agreement (VPA) process and potential modifications needed for the VPA in the context of RTCs. Tennille Thomas explained that the purpose of the VPA is to assist families with payment for services. It is especially helpful for those families who are experiencing difficulties identifying suitable RTCs and covering the costs associated with placing individuals into RTCs. She noted that the payment for these placements are covered by DHS rather than Medicaid. Ms. Neral asked what specific language about the VPA process should be included. Ms. Lord and Ms. Thomas noted that there is interagency work being done on the issue, and they agreed to follow up later.

Tammy Loewe commented on the VPA process too. She mentioned that legislation passed in 2022 (HB 766/SB 656) allows local behavioral health authorities to bypass VPAs for individuals without individualized education plans (IEPs) who require RTC placement and provides funding for the education of those youth while in an RTC. Ms. Thomas emphasized that the process for implementing the change has not been determined. (The effective date of the change is fiscal year 2025.)

Ms. Fleck thanked work group members for feedback on the White Paper. She added that members are welcome to email staff with additional feedback.

MHCC Certificate of Need Review Process

Ms. Fleck briefly explained the review process for CON projects. She explained that there are specific criteria and standards applied to these projects, both general requirements outlined in procedural regulations and specific requirements related to the type of project or service being proposed. She noted that many of the current standards for RTC projects are outdated because the CON regulations for RTCs are over 20 years old; some of the standards are considered irrelevant and disregarded in the CON review process. She explained the CON standards will be discussed in detail later in the meeting, but she can answer questions if people have them. She stated that the Board of Childcare report provides a good example of how CON standards for RTC projects

are applied. She mentioned there is also an RTC project where an applicant withdrew the project based on staff recommending denial of the CON. Sometimes projects are withdrawn before the Commission can consider them.

Discussion of New Draft Policies

Ms. Fleck opened the discussion on the development of draft policies for the State Health Plan (SHP) chapter for RTCs by explaining that the policies are intended to outline the principles that will guide the standards included in the SHP chapter for RTCs. She mentioned that the current chapter for RTCs is outdated and does not include a list of policies, which is common in other SHP chapters. She proposed going over each of the draft policies provided in a handout and discussing whether these policies effectively capture the principles that should guide the standards in the regulations.

Draft Proposed Policy 1:
RTCs shall coordinate and work together with referral agencies for RTCs, hospitals, and other community providers to create and maintain a seamless mental health system that offers a comprehensive continuum of care for children and adolescents in Maryland.

Ms. Dewey expressed concerns about the language used in the proposed policy, specifically regarding mental health services. She suggested that "behavioral health" is a better term to use than “mental health” because some youth may have co-occurring diagnoses that require connections to support services beyond just mental health care provided by RTCs. She advocated for a broader approach that encompasses a wider range of mental health and behavioral support services to better meet the needs of individuals with co-occurring diagnoses. Dr. Maehr agreed that the term “mental health” is too narrow.

Ms. Dewey also asked about the intention of the policy and whether the intent was to focus on coordination with other providers, or family and other informal support too. She suggested changing the policy language from general terms like "community providers" to more explicit descriptors such as "home and community-based service providers and supports." She explained that this change will show the importance of engaging and coordinating natural support, such as family and friends, alongside formal care structures.

Ms. Fleck read the second proposed policy and asked for feedback on it. Dr. Maehr proposed to refine the language regarding the type of care these centers should provide. Instead of simply stating "care," she suggested adding descriptors like "high quality" and "evidence-based" because the policy seemed overly focused on cost-effectiveness.

Draft Proposed Policy 2:
Residential treatment centers shall provide care in the most cost-effective manner for the healthcare delivery system that is consistent with safely and appropriately meeting the health care needs of the population served by RTCs.

Ms. Dewey noted that it is important to consider the inclusion of families in the policies being discussed. There is no mention of “families and education” in the policies under

consideration. Claudette Bernstein, M.D., agreed. Ms. Thomas agreed with Ms. Lord and highlighted the importance of including elements such as the "system of care" and values regarding engaging family and natural support in the treatment plans for children and youth. She pointed out that many kids end up returning to an RTC because, although they were given referrals to individual providers, the entire family was not provided with an effective plan tailored to their needs. Ms. Lord suggested that this issue is not anyone's fault, but rather a challenge inherent in the system. She advocated for starting with the intention of including comprehensive support from the beginning to prevent the need for readmission of youth into care.

Mr. Mroz mentioned that RTCs offer mental health treatment, family therapy, and education. He commented that education is a large part of the treatment provided in an RTC, but he acknowledged that oversight is through the Maryland State Department of Education, so he was unsure about whether to mention in policies. Ms. Fleck asked what other people think about including education. Ms. Dewey, and Dr. Maehr agreed that education is an important component of treatment in RTCs. Ms. Fleck then read the next draft policy statement, as shown below.

Draft Proposed Policy 3*:*
Residential treatment centers shall be accessible to children and adolescents who need to be treated in them. RTCs will strive to reduce barriers to service for the underserved populations that stem from finances, geography, race, ethnicity, or gender.

Ms. Fleck explained that the focus is on ensuring that all individuals, regardless of their backgrounds, can access the necessary treatment and support provided by RTCs. Dr. Maehr expressed concern about including other underserved populations, particularly immigrants. She asked whether they should be specifically mentioned in the policy. She also explained that she has noticed an increased need for substance use treatment and RTC care among immigrants in the District of Columbia metropolitan area. She also commented that access to RTCs is very difficult for youth with significant substance use disorders and other health conditions, such as pregnancy.

Catherine Gray agreed that health conditions can be a barrier to children accessing RTCs. She noted that it is not just eating disorders that can pose challenges, but also complex medical conditions such as developmental disabilities and other health issues like diabetes. These health conditions may prevent a child from being accepted into an RTC.

Shawn Lattanzio suggested including language about cultural competence. Another work group member agreed and added that access for families to see their children is also important. Ms. Fleck asked how common it is for patients to have complex medical problems. There are only one or two RTCs who can treat those patients. Ms. Lattanzio noted that she had a patient denied care in an RTC because of diabetes that required frequent injections. Ms. Dewey stated the same problem exists in Baltimore County; if a youth has insulin dependent diabetes, the youth will have to be treated out-of-state typically. She also noted that the primary reason for RTC placement is a mental health issue, but there still needs to be the ability to handle secondary issues, whether it be a medical issue, developmental delay or other secondary issue. Ms. Gray agreed.

Eliot Burkham noted that there were two comments in the chat box on Policy 3 from Mr. Buchdahl and Dr. Bernstein. Ms. Fleck read the comments to the group. Dr. Bernstein suggested that language be added and that RTC should be accessible to children, adolescents, and their families. Mr. Buchdahl proposed differentiating gender from gender identity.

Ms. Fleck commented that it sounded like certain RTCs are better equipped to handle complex medical cases, while others may deny acceptance based on medical needs. She asked if that was acceptable or if the work group felt there should be a change. Ms. Dewey asked what would be required for all RTCs to have 24/7 nursing. It was suggested that the medical directors of RTCs should be consulted. Ms. Fleck agreed and encouraged work group members who represent RTCs to contact the medical directors at their RTCs.

Drew Pate, M.D., the medical director at RICA Baltimore, commented that all decisions are made individually. For example, a patient with diabetes who manipulates insulin for self-harm is hard to manage in an RTC, but a patient with diabetes without that issue may be accepted. His decision is based on the risk to a child.

Ms. Dewey asked about what support is needed so more RTCs can serve patients with medical issues. Dr. Pate stated that having specialty facilities or units makes sense. He stated that the three types of patients who are most often turned down by RTCs fall in three categories: those with developmental delays, those with complex medical needs, and those who engage in extreme self-harm behaviors. He added that he has 32 years of experience in RTCs, and he has seen patients in those groups sometimes decline because their needs are not adequately met in an RTC without the highly structured specialized programs needed.

Ms. Neral asked if there are certain out-of-state RTCs that typically take the children who cannot be served in a Maryland RTC. Dr. Pate stated that is the case; Cumberland is one facility that can serve children with complex needs; for children with developmental delays that need an institutional applied behavioral analysis (ABA) program or those who engage in extreme self-harm that require dialectical behavioral therapy (DBT), there are a few programs scattered around the country. However, it is difficult to get children into them. He stated that Maryland has the resources and population to potentially develop internal programs to address these needs locally.

Ms. Dewey mentioned that one patient was accepted to Devereux in Florida, but the child has been waiting for two years for a bed. Also, some Maryland Medicaid approved programs may not have the services a child needs and they must go out-of-state for that reason. They access alternative programs through Social Services. She suggested checking on the number of children served out-of-state. Ms. Thomas noted that data is tracked by DHS.

Dr. Maehr commented that it would be interesting to look at the reasons for denial. She added that DJS facilities must take care of everyone. DJS facilities have had to provide care for post-operative children, those with diabetes (including those who have engaged in self-harm with insulin pumps), and those with opioid use disorder. It does require continuous nursing care and one-on-one attention from specialists, such as endocrinologists. Such cases require significant time, effort, and coordination with medical specialists. She further suggested RTCs need compensation to provide this level of care.

Dr. Maehr asked whether RTCs have infirmaries that are equipped to handle medical emergencies. Dr. Pate responded that there are no infirmaries in RTCs. He mentioned that when a child falls ill, the child is typically isolated within the building, often on the unit, to prevent spreading illness to other children. Because many RTCs do not have dedicated medical staff onsite during the day, it creates challenges in providing medical care and ensuring the child's safety.

Ms. Dewey commented that a good example of system barriers to accessing an RTC is that Chesapeake Treatment Center is a Medicaid-approved RTC, but it is only accessible if DJS is involved. It is also one of the few RTCs that will provide treatment for youth demonstrating sexualized behaviors. Nexus-Woodbourne also has a specialty RTC program for kids with problematic sexual behaviors.

Dr. Pate stated that there are now fewer RTC options compared to when he first started, over 30 years ago. He noted that there were previously more beds in treatment facilities, more substance use centers willing to take in young individuals for residential treatment, and more group homes.

Ms. Fleck read a comment from Dr. Bernstein in which she suggested there is a need for higher pay to incentivize the recruitment and retention of RTC staff who work with more acute patients. With the hospital step-down population there is a higher risk of patient assaults. Higher pay could help mitigate these risks and improve patient care. Ms. Fleck next read draft policy 4, as shown below.

Draft Proposed Policy 4:
All residential treatment centers shall continuously and systematically work to improve the quality and safety of patient care, including by evaluating the efficacy of services provided by RTCs through outcome measures.

Ms. Dewey suggested a modification to broaden its scope beyond just focusing on patient care. She specifically suggested Policy 4 be revised to state:

All residential treatment centers shall continuously and systematically work to improve the quality and safety of patient care and caregiver/guardian engagement and support, including by evaluating the efficacy of services provided by RTCs to youth and their caregivers/guardians through outcome measures.

She explained that the purpose of the change is to shed light on the importance of involving and supporting the individuals responsible for the care of the youth in RTCs and the caregivers/guardians of youth. Mr. Buchdahl and Ms. Lattanzio agreed. She noted that the local behavioral health authorities also make referrals to RTC for children and youth who have non-public school IEPs and meet medical necessary criteria for RTC placements. Ms. Thomas agreed as well. Dr. Pate commented on the importance of incorporating language that supports the implementation and continuation of best practices and evidence-based treatments.

Ms. Fleck commented that MHCC staff heard from RTCs that it can be challenging to obtain feedback about outcomes for youth after they have left the RTC facility, despite efforts made to follow up multiple times. She asked if the lack of feedback raises concerns about the feasibility of obtaining information for outcome measures. Ms. Dewey asked about the possibility of incorporating additional data sources, such as claims data or analyses from other organizations, into the outcome measures collected by RTCs. She mentioned that for children who have been admitted to RTCs multiple times, there would likely be claims data associated with their care. She suggested that this data could be provided back to RTCs after a youth is discharged, even if it's de-identified, to potentially improve the effectiveness of treatment and inform future care decisions. Ms. Fleck asked work group members for feedback on this suggestion. Ms. Lattanzio agreed with the suggestion.

Ms. Fleck read the next proposed policy and asked for feedback. The policy is shown below.

Draft Proposed Policy 5:
Residential treatment centers shall consider smart and sustainable growth policies, as well as green design principles in facility or center design choices.

Ms. Dewey asked about the meaning of sustainable growth policies in the context of the policy provided. Ms. Fleck explained that it refers to the geographical area where development or expansion of an RTC is planned. Ms. Thomas noted that most RTCs are centrally located and accessible by bus lines, which enables youth to leave without permission. She asked if the policy considers how the infrastructure and the locations of RTCs affect youth and the surrounding community's safety. Ms. Fleck responded that the policy does not, and she asked work group members if it should be incorporated into policies. There were no additional comments from other work group members. Ms. Fleck asked if the issue should be reconsidered later, after work group members had more time to think about it.

Certificate of Need (CON) Review Standards

Ms. Neral referred work group members to handout #2, which has the regulations that apply to the evaluation of need for an RTC project. Both procedural regulations and the SHP chapter for RTCs apply to the review of a CON for an RTC project. She noted the procedural regulations were just updated, but the SHP chapter for RTCs has not been substantively revised for over 20 years. She explained that according to the procedural regulations, the Commission must consider the applicable need analysis in the SHP and, if none is applicable, evaluate whether the applicant has demonstrated need for the proposed project.

Ms. Neral then explained how a recent CON application for a four-bed RTC was handled (Board of Child Care). Staff determined the need analysis described in the SHP chapter for RTCs was obsolete, and instead assessed whether the applicant had demonstrated a need for the RTC. The applicant cited analysis for the Adolescent Hospital Overstay Grant program, which projected an initial need of 18 beds for adolescents, based on an estimated 25 adolescents needing treatment annually. The applicant also referenced a report by the Maryland Hospital Association on the Pediatric Hospital Overstay Data Collection project.

Ms. Neral then asked work group members for feedback on what data sources should be used to evaluate the need for RTCs. Ms. Dewey inquired about access to claims data related to high inpatient or high emergency department utilization for primary mental health care among youth, specifically in Maryland. She acknowledged that it would not capture the need for RTC care specifically. Ms. Fleck stated that HSCRC hospital discharge and outpatient data would capture inpatient psychiatric visits. Ms. Dewey suggested CRISP data or claims data may also be used.

Ms. Fleck noted that some information available for CON review of the Board of Child Care RTC would likely not be available every year for future reviews of RTC projects. Mr. Mroz commented on different data sources used to track the need for placements in RTCs. One source is the 211 press 4 phone system; hospitals can report on the needs of individuals stuck in emergency departments or some of those already admitted. Another source is the Behavioral Health Administration's placement teams actively calling to assess the unmet needs of patients. Mr. Mroz suggested integrating this data with information on current RTC residents and their needs, as a way to identify individuals whose needs are not being met.

Ms. Dewey commented that she thought local care teams' data might capture unmet needs for RTC care. She pointed out that simply looking at the number of kids accessing RTCs does not capture those unable to access RTCs. She mentioned that this information might be available through scorecards published under the Governor's Office of Crime Prevention, Youth and Victim Services.

Ms. Fleck asked whether the collection of data on RTC utilization and the need for these services should be the responsibility of a State agency, which then shares the information with the public. By making this information publicly available, individuals or organizations interested in addressing these needs, by expanding or establishing services, would have access to the necessary data to inform their decisions.

Ms. Neral asked if there is a process to track denials by RTCs that might shed light on the need for RTCs. There were not comments in response to her question. She suggested returning to the issue of data collection again later.

Ms. Neral asked how the need for additional beds in an existing RTC should be determined. She pointed out that RTCs have a certain number of licensed beds, but not all of them are currently staffed. RTCs can expand up to the licensed number of beds without needing to go through the CON process.

Ms. Fleck explained there may be a dilemma about whether to approve a CON for a new RTC when there is already licensed capacity for beds in existing RTCs, but the beds are not all staffed. Ms. Dewey commented that the nuances of the data regarding why certain kids are not able to be admitted into a facility is relevant to the issue. She noted that simply adding more beds may not solve the issue if the new beds do not meet the specific needs of the population that has difficulty accessing RTC beds. These needs could include complex medical conditions, developmental disabilities, substance use disorders, sexual behavior issues, or aggression. She suggested that evaluating proposals for new facilities should involve assessing whether they can

cater to populations that are currently underserved. If an RTC is willing to accept and address the needs of children who are currently not being placed elsewhere, then adding new beds could be helpful.

Dr. Pate suggested that if an RTC has licensed beds that are not being filled due to staffing or other reasons, there should be a mechanism in place to reallocate those beds to other facilities or organizations that could better serve the population in need. Ms. Fleck explained that when someone receives a CON, there is typically a timeline to take action and follow through with the process. However, there is still a question about what criteria or guidelines MHCC staff should use to evaluate the need for a CON.

Mr. Mroz commented that a challenge faced by organizations such as the Board of Child Care is filling staff positions. He acknowledged that while there may be a desire or need to increase capacity by opening new beds, the primary limiting factor is the ability to adequately staff these units. He suggested that even if more beds are granted or made available, an RTC may struggle to fully staff them, potentially leading to a situation where only a portion of the beds can be utilized effectively. The main issue lies in the availability and recruitment of qualified staff. Second, the capacity of the facilities is determined partly by the infrastructure, such as the number of beds available, and how these beds are configured (e.g., single rooms versus shared rooms). He explained that certain types of cases, such as children with high sexual acting out behavior or violent tendencies, may necessitate allocating a room for one child instead of two children, effectively reducing the available capacity. This was particularly true during the COVID-19 pandemic when single rooms were required, leading to fewer beds being usable.

Mr. Mroz further stated that high-acuity cases require more intensive staffing, potentially limiting the number of children an RTC can accommodate since staff resources are redirected to address these cases. This staffing allocation can further impact the utilization of available beds. Mr. Buchdahl agreed with Mr. Mroz. Ms. Fleck asked how to resolve this issue. Mr. Buchdahl commented that financial reimbursement has to be increased in order to be able to recruit, hire, and retain enough staff to handle high acuity patient cases.

Ms. Dewey commented that there is a list of approved RTCs for Maryland Medicaid recipients exists, but usually a couple of these do not accept Maryland kids. This creates confusion and skews the numbers, making it difficult to accurately evaluate the need for beds. She added that some RTCs have reduced their capacity, which further complicates the issue. Ms. Lattanzio noted that the local behavioral health authorities' also make referrals to RTCs for children who have IEPs for nonpublic schools and who meet medical necessity criteria for RTC placements.

Ms. Neral asked if the unused licensed capacity of existing providers should be seen as a sign of insufficient demand for services or a need for more capacity. Based on recent discussions, staffing could be a significant limiting factor, and unused capacity might not necessarily indicate a lack of demand for services. A work group member agreed.

Ms. Fleck asked if applicants should be required to address their ability to recruit staff as part of the CON review process. Ms. Thomas commented that it is reasonable to require plans, but plans do not always work out as expected. One of the challenges faced by RTCs is maintaining

adequate staffing, particularly in the context of competition for staff between RTCs and other providers. It may not be possible to hold RTCs accountable for adhering to those plans. For example, the Board of Child Care claims to have staff available but are not currently accepting new youth placements.

Ms. Dewey asked about whether there is a procedure within the CON process for an RTC to either utilize the allocated beds within a stipulated timeframe or surrender the beds if they remain unused. Ms. Gawal explained that with a CON, staffing levels are considered at the time of application. She also noted that a condition can be placed on CON that requires reporting on staffing levels after a project is implemented. Ms. Likova added that during licensure inspection, if there is not adequate staffing, no license would be issued.

Ms. Neral noted that earlier in the meeting, it was mentioned that during the COVID-19 pandemic, there was a need to place individuals in single rooms rather than double occupancy rooms to mitigate the spread of the virus. She asked if this should be taken into consideration when updating standards, implying that perhaps there should be a shift towards single occupancy rooms. She noted that this change has been made for other services. Ms. Fleck agreed. She noted the trend in hospitals is to provide private rooms instead of semi-private rooms.

Ms. Likova explained that the hospitals are required to follow standards from the Facility Guidelines Institute, which emphasize the provision of private rooms for patients. However, when it comes to mental health facilities, there is often a preference for shared rooms over private ones. She suggested that staff for RTCs further explain. Mr. Buchdahl commented that advocating for single rooms over double rooms is reasonable, given the recent type of referrals being received; it is the way to go in the future. Other work group members agreed.

Elizabeth White added that Sheppard Pratt currently has several different contracts in place regarding one-to-one staffing and single bed occupancy in order to accommodate children with higher acuity needs. Dr. Maehr agreed that single rooms are also better to medically isolate patients.

Ms. Neral asked if MHCC should consider establishing a minimum bed requirement for new RTCs. Dr. Maehr explained that a four-bed model appears to be expensive considering the required nursing and physician coverage. She questioned whether there would be sufficient value for the cost. She added that while it is beneficial to have a small setup, the RTC may not be able to serve children with higher needs, particularly if the facility operates 24/7.

Ms. Dewey responded to Dr. Maehr's comment by pointing out that the Board of Child Care secured grant funding to bolster its operations. She asked whether it would be prudent to enforce a requirement for single or double occupancy beds or to set a minimum bed capacity. She suggested that imposing a specific model might deter potential applicants if it does not align with the prevailing reimbursement rates. The Board of Child Care was able to navigate this because of a substantial grant to support both nonpublic education and RTC reimbursement needs.

Ms. Likova noted that The Board of Child Care has four beds, but it has sufficient staffing with 24/7 nursing coverage in the unit. It can support a staffing ratio of two to one for the four

beds. Ms. Dewey commented that without the grant, the Board of Child Care will not be financially sustainable as a standalone RTC with the same model. Ms. Gawal added that part of the intention is to demonstrate the necessity for increased staffing and reimbursement for RTCs. By gaining firsthand experience and data, the aim is to highlight the critical need for these resources to effectively support and care for the target population.

Ms. Dewey expressed concern that if regulations are updated to establish minimum standards such as single rooms or a specified number of beds, and reimbursement rates do not align with that model, there is a risk of losing potential applicants. This could potentially lead to a stagnant situation for another decade until the regulations are revisited.

Dr. Pate commented that if there is a need for a specialized residential RTC or a smaller-sized facility, then setting a size limit might not be advisable, as highly specialized units often require smaller, more intensively staffed environments to effectively meet the needs of their clients. Mr. Buchdahl added that it is going to be challenging to find organizations willing to apply to become an RTC until reimbursement for staff is increased. RTCs need to pay staff enough to attract the caliber of employees that they desire. Additionally, some organizations may hesitate if grant funding is involved, as it is not always sustainable in the long term. Investing a lot of effort into building something that might not be financially viable in the future could deter potential applicants.

Mr. Mroz agreed with Mr. Buchdahl's points, and the sentiments shared by others. It is evident that sustaining these programs hinges on navigating fluctuating rates and ensuring their financial viability. In the past, despite efforts to attract individuals interested in establishing specialty beds, practical concerns persist. As someone focused on operational efficiency, it is essential to acknowledge that managing highly complex and acute cases poses significant risks. While RTCs share a genuine desire to support these kids, the reality is that managing severe cases carries inherent challenges; financially, logistically, and in terms of safety. While there's no question about collective goodwill, from a management standpoint, it is crucial to weigh the risks associated with accommodating extremely challenging cases. This cautious approach often limits capacity to take on such cases, thus hindering program sustainability. The balance between risk management and program expansion has proven to be a considerable hurdle in our efforts to enhance and broaden these services.

Ms. Fleck asked how these concerns should influence our approach to CON projects. Ms. Dewey suggested that preferences be incorporated, such as a preference for single-bed capacity, based on available data or current models. The aim would be to highlight bed needs and preferences without making them mandatory. Ms. Fleck noted that it is feasible to implement regulations with softer language that refers to a target, preference, or goal rather than an absolute standard. Ms. Dewey suggested incorporating preference language that aligns with our policies and emphasizes support for workforce development and capacity-building initiatives. This approach would bolster our overall application without unduly limiting providers' willingness to apply.

Ms. Fleck noted that it was approaching noon. She asked if anyone had any comments or questions on the standards included on the agenda. No one had additional comments or questions. Ms. Fleck expressed gratitude for everyone's participation and patience while staff resolved the technical difficulties at the beginning of the meeting.

Ms. Fleck asked for feedback regarding whether future meetings should be conducted online only or include in-person attendance options. It was agreed that hybrid meetings are preferred.

Ms. Fleck suggested early April for the next meeting. She explained that another poll will be sent out to establish the best date. She asked participants to share any preferences or constraints they may have regarding meeting times. Mr. Mroz suggested that the next meeting be held after the legislative session ends. Ms. Fleck agreed to hold the next meeting after April 8. Ms. Fleck again expressed appreciation for all of the feedback in the White Paper. She encouraged others to provide comments, questions, or additional feedback on the regulations and the White Paper.

Dr. Maehr noted her intention to send an email with additional feedback on the White Paper. She stated a correction to the White Paper was needed on page three, related to DJS levels 1 to 3. Ms. Fleck adjourned the meeting.