CHILD AND FAMILY WELLBEING

RECOMMENDATIONS

Prepared For:
Moore-Miller Unlocking Opportunities and Health Policy Committees
December 2022

PREPARED BY:

100 YEARS CATHOLIC CHARITIES
CHERISHING THE DIVINE WITHIN ALL

Disability Rights Maryland

2023 PROJECT

NASW MARYLAND CHAPTER
National Association of Social Workers

Maryland Association of Resources for Families & Youth

Behavioral Health System Baltimore

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND CBH

SCCAN Maryland's State Council on Child Abuse and Neglect

Arrow CHILD & FAMILY MINISTRIES
Helping Kids ~ Strengthening Families

MARYLAND essentials for childhood

Hearts & Homes for Youth

MAYSB Maryland Association of Youth Service Bureaus

Thank you for considering these recommendations. For more details related to these ideas please contact: Regan Vaughn rvaughan@cc-md.org

INTRODUCTION

A coalition of Maryland stakeholders developed recommendations and action steps to support Governor-elect Moore in making Maryland a leader in social services for children and their families that ensure children are safe, experience a greater level of wellbeing and help families remain intact. The group focused on interactions between the Governor's office, Department of Human Services (DHS), Department of Health (MDH) and adjacent agencies and programs that comprise the children's system of care in the state. Workgroup topics of discussion included but were not limited to the following challenges: barriers to inter-agency collaboration; inadequate funding; inadequate pace for implementing reforms, including Family First Prevention Services Act (FFPSA); and an overall lack of key programs and infrastructure including a qualified workforce, mental health services and treatment options, community-based services, and foster homes. Together, DHS and MDH are responsible for a full continuum of care for Maryland's children. The challenges detailed in this report represent an opportunity for the new administration to course-correct the agencies caring for Maryland's children beginning with cross-agency collaboration, stakeholder involvement, data-driven decision-making, and clear lines of authority to solve problems.

KEY TAKEAWAYS

- ➔ The Department of Human Services Social Services Administration should be an agency whose mission is to care for children and youth at risk of or experiencing maltreatment through a focus on child well-being, Families First prevention services, and a collaborative suite of care services that meet the needs of children and youth across the state.
- ➔ The Governor's Office for Children should be renewed as a stand alone office empowered to execute the vision of the Children's Cabinet and should serve as a nexus of coordination, collaboration, and coherence for child serving agencies with a focus on identifying gaps in the system, fostering cross-agency collaboration, and coordinating problem solving initiatives.
- ➔ The Maryland Department of Health Behavioral Health Administration should ensure that Maryland's public behavioral health system includes robust home and community-based services capable of addressing the full spectrum of children's mental health and substance use needs.
- ➔ Maryland Medicaid should ensure that children in foster and kinship care receive all healthcare services mandated through the EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) program and that receipt of these services is coordinated with and data shared with Maryland DHS and LDSS agencies.

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CRITICAL DOCUMENTS

RECOMMENDATIONS

RECOMMENDATION #1: Appoint knowledgeable leadership to Department of Human Services (DHS) secretary and Social Services Administration (SSA) director positions.

Context: The Secretary of the Department with Human Services has immense responsibility for the well-being of vulnerable children, youth and adults throughout the State. DHS is the Department of last resort where families turn when other systems fail to meet their needs. It is the backbone of our social safety-net. The COVID pandemic demonstrated the important role the Department plays in supporting families. Unfortunately, it also exacerbated weaknesses in our system - a lack of appropriate placements, insufficient technological infrastructure, and a declining workforce. The next Secretary of DHS must be a visionary leader who understands the urgent nature of the work and can work in a collaborative manner to implement needed reforms.

The Executive Director of the Social Services Administration will be responsible for repairing the State's child welfare system which has been decimated by years of high turnover and disinvestment. The Executive Director will need to address the urgent issue of children languishing in hospitals, hotels and DSS offices due to lack of appropriate placements while also strengthening prevention programs implementing the federal Families First Prevention Act.

First 100 Days • **Appoint a Secretary for the Maryland Department of Human Services who:**

- ➔ Has professional qualifications and expertise in child serving systems, including:
  - ◆ A demonstrated ability to set a clear vision
  - ◆ Experience working with providers and stakeholders in a collaborative manner
  - ◆ The ability to communicate effectively with numerous constituencies
  - ◆ An understanding of the urgent nature of the work
- ➔ Believes DHS should:
  - ◆ Be an inclusive, informed, diverse and responsive agency;
  - ◆ Work in concert with the local Departments of Social Services to assess, plan and implement strategies that will improve statewide and local services to children and families;
  - ◆ Collaborate with service providers, advocates and other professionals that work on poverty alleviation, economic self sufficiency, and child welfare to improve the well-being of Maryland's children and families.
- ➔ Preferred experience:
  - ◆ Strong leadership qualities that allow them to be the advocate for children and families, lead coordination with other secretaries, and set a vision for the Agency.
  - ◆ Experience with child serving and benefits administration systems.
  - ◆ Good collaborator with internal and external stakeholders with a track record of success.

First 100 Days • **Appoint an Executive Director of the Social Services Administration who:**

- ➔ Has professional qualifications and expertise in child serving systems, including:
  - ◆ A demonstrated ability to implement large scale projects

- ➔ Believes DHS should:
  - ◆ be an inclusive, informed, diverse and responsive agency;
  - ◆ work in concert with the local Departments of Social Services to assess, plan and implement strategies that will improve statewide and local services to children and families
  - ◆ collaborate with service providers, advocates and other child welfare professionals to improve the well-being of Maryland's children and families
  - ◆ recognize that behavioral health issues are the number one driver of foster care entries, and therefore should partner closely with the Behavioral Health Administration to jointly support families with community based services to prevent foster care placements.
  - ◆ Recognizes that as the guardian of children in foster and kinship care, the state is responsible for ensuring receipt of necessary medical, developmental, and dental health services and needs to partner closely with Maryland Department of Health to meet these needs.
- ➔ Preferred experience:
  - ◆ Experience with child serving systems
  - ◆ Good collaborator with a track record of success

RECOMMENDATION #2: Address the placement crisis for youth with behavioral health needs.

Context: The lack of placements for youth with moderate to significant behavioral health needs has been a deepening crisis for years. As a result of the shortage, youth are languishing in psychiatric hospitals meant to be short-term, "boarding" in emergency rooms, and now, sleeping in DSS offices and being 'placed' in hotels with purchased supervision and gift cards for fast food.. The length of hospital in-patient overstays in calendar 2020 and 2021 is particularly high for psychiatric hospitalizations compared to medical hospitalizations. DHS and other child placing agencies continue to evaluate how to address service gaps in Maryland that contribute to hospital overstays" (DLS Analysis of the FY 2023 Maryland Executive Budget, 2022)

Unfortunately, this is not a new problem for Maryland. In 1987, Lisa L v. Sabatini was filed on behalf of children committed to State custody who remained in psychiatric hospital placements beyond clinical necessity. The state entered into a consent decree in 1993. The challenge of placements for youth with high intensity behavioral health needs was once again identified as a challenge in 2002 when a Roundtable was convened to develop potential solutions.

In 2008, the Children's Cabinet released its interagency strategic plan which provided a roadmap for improving the family-serving systems with the goal of increasing community supports and decreasing congregate placements. Between 2007 and 2015, over 350 DHS and MDH licensed congregate care beds closed. A desire to treat children in their homes and communities is shared by advocates and families, but the enhanced community-based supports required to do so never materialized. In fact, many of those supports decreased further. The state has all but dismantled high-fidelity wraparound services, increased eligibility requirements for services, decreased access to services designed to work together, and funded

provider rates so inadequately that agencies have had to shut down programs designed to serve kids with complex needs.

A handful of attempts to address this crisis have been made. The Children's Cabinet prepared an Interagency Plan to address the shortage. The report incorporated many of the recommendations that were in the 2008 strategic plan, but implementation has been deeply insufficient. In 2022, MDH released an RFP to create more adolescent treatment beds. There was no response from the provider community due to the rate inflexibilities, the ongoing workforce shortage and lack of confidence in the system to support providers. There have been no attempts to address the inadequate array of home and community-based services designed to prevent children from requiring inpatient levels of care and out-of-home placements.

The result has been front line workers in the local DSS and behavioral health authorities left scrambling for options for families. Without appropriate placements, those options are leaving children in hospitals beyond medical necessity, placing youth in hotels and housing them in DSS offices.

Soaring mental health needs of children during the pandemic has exacerbated this crisis, but the barriers to service access in the community and appropriate child welfare placements have remained unaddressed, and agency responses have lacked the sense of urgency for which the situation calls for.

Recommended Actions

First 100 Days **• Issue an Executive Order mandating the Children's Cabinet prioritize ending the placement crisis for youth with disabilities and behavioral health needs and include the following steps.**

- ➔ Assign a representative of the Governor such as the Chief of Staff or Lieutenant Governor to chair the cabinet, ensuring interagency cooperation, providing oversight and managing problem-solving.
- ➔ Allow for the creation of a subcabinet focused on the issue consisting of MDH and BHA Deputy Secretaries, the state Medicaid Director, Behavioral Health Administration Director, Social Services Director and other local Department of Social Services (LDSS) representatives
- ➔ Require quarterly open meetings and the engagement of stakeholders in the process.
- ➔ Ensure appropriate funding is being allocated to DHS, BHA and LDSS to address the crisis and to make sure agencies can act without delay because there aren't enough resources.
- ➔ Examine provider rates and increase reimbursement rates for all staff and services that provide services to children. Quickly increase funding for lagging provider rates and complete the stalled rate reform process.
- ➔ Complete a capacity study (similar to Oregon) to determine what placement resources are needed and develop a plan of action based on the outcome.
- ➔ Provide immediate support to LDSS offices to address costs and move children out of hotels and into stable placements.

First 100 Days **• Order DHS to issue an emergency procurement to establish a 25 bed "no eject, no reject" high-intensity psychiatric emergency respite facility.** The respite facility is intended to be a temporary fix until the appropriate community based services are established and the log jam within the system is eased. If executed quickly, this facility could be opened within the first 90-180 days of the administration.

- ➔ Given the number of closed programs in recent years, there is existing infrastructure that could be reopened with minimal barriers.
- ➔ The rates should be set outside the IRC process. DHS must ensure that the provider(s) have the ability to provide for the individual needs of each child including the ability to adjust rates and staffing ratios. It is critical that the program's acceptance criteria are meticulously negotiated.

First 100 Days • Order BHA to establish a care management entity (CME) that can provide high-fidelity wraparound coordination services for youth and their families.

- ➔ The CME should not be limited to Medicaid recipients.
- ➔ The CME should be involved through the life of the case from the hospital to respite to discharge from respite and placement in the community.
- ➔ The CME should not require eligibility be limited to families involved with child welfare.

First Year • Expand treatment options for youth.

- ➔ BHA and DHS should develop a 90-day action plan to right-size the capacity of high-intensity treatment residential facilities (Residential Treatment Centers, Qualified Residential Treatment Programs, high intensity group homes, diagnostic and stabilization services, psychiatric inpatient beds, etc..) so that they are fully staffed and have the flexibility to meet the individual needs of youth.
- ➔ BHA should build out the intensive in-home services for youth with behavioral health needs currently being offered through the 1915i Medicaid waiver and Targeted Case Management and remove barriers to accessing these services.
    - ◆ Services should include Family-Centered Treatment, Functional Family Therapy, and other Evidence Based Practices
    - ◆ Reimbursement for services should reflect cost to deliver the model
    - ◆ Open up spots for youth with private insurance
    - ◆ Remove service combination exclusions for youth receiving psychiatric rehabilitation services, including targeted case management and respite services
    - ◆ Eligibility requirements should be amended so that families can access services before reaching a crisis point
- ➔ DHS should evaluate and create a plan for low intensity residential options for youth who can succeed in independent living with extra supports. Interagency partnerships and regulatory flexibilities similar to what was demonstrated when Maryland ended its relationship with Advoserv in Delaware will be required.
- ➔ The new Governor's Office for Children should create a plan to restore and expand funding for Early Prevention and Intervention services through Local Management Boards, including Youth Service Bureaus.

First Year • MDH should fully fund the Mobile Response and Stabilization Services (MRSS) crisis model that is currently being implemented statewide. MRSS is a strategy designed to de-escalate a crisis before more costly interventions are needed.

First Year • **DHS should evaluate potential reforms to the foster care program including:**

- ➔ Providing treatment foster parents with the resources they need to be successful caregivers and meet the needs of foster youth in their care without requiring them to have additional income sources in recognition of the additional, and often complex needs of treatment foster children.
- ➔ Increasing the likelihood of family reunification by taking advantage of new federal guidance to end the practice of establishing child support orders for costs related to their child being in foster care.
- ➔ Improving the delivery and record keeping of health services for youth.
  - ◆ Integrating state data systems (e.g. CJAMS, Medicaid, CRISP, Immunet) so that DHS has access to health care information for children involved in their systems and so that Medicaid and primary care providers can identify when children are placed in foster care.
  - ◆ Use this information and other information as needed (e.g. primary care records, hospital records, immunizations) to create an electronic health passport.
  - ◆ Providing support to LDSS agencies so that they can ensure access to and quality of care of medical services for youth interacting with CPS, foster care, and in-home services programs.
  - ◆ Providing better oversight and peer review for providers doing medical assessments of foster youth.
- ➔ Developing a comprehensive public/private foster parent recruitment plan.

Sources & Supporting Resources

- ➔ DLS Analysis of the FY 2023 Maryland Executive Budget, 2022
- ➔ DRM Cases in Active Litigation as of June 26, 2022
- ➔ 2002: Department of Human Resources Roundtable Report on "Stuck Kids"
- ➔ Interagency Plan: Developing Resources To Address the Complex Needs of Maryland Youth in Care (State of Maryland Children's Cabinet, 2020)
- ➔ Identifying Capacity Needs for Children within the Oregon Child Welfare System
- ➔ Applying Implementation Science to Wraparound: What Should We Measure? (Institute for Innovation and Implementation)
- ➔ Joint Letter Regarding the Assignment of Rights to Child Support in Foster Care (Administration for Children and Families' (ACF) Children's Bureau (CB) and Office of Child Support Enforcement (OCSE))
- ➔ NASW Recommendations
- ➔ Foster Kids Continue To Be Left Behind In Hospitals, MD Reporter 2022
- ➔ Treatment Foster Care in Texas: A Mixed Methods Descriptive Analysis (Texas Alliance of Child & Family Services, March 2021)
- ➔ 2021 California law mandating the creation of 'crisis psychiatric respite treatment programs'
- ➔ MD GOC - Local Management Boards

- ➔ MDH Mobile Response & Stabilization Services Fact Sheet
- ➔ States Should Use New Guidance to Stop Charging Parents for Foster Care, Prioritize Family Reunification
- ➔ Ch 407 of 2018 - Human Services - Children Receiving Child Welfare Services - Centralized Comprehensive Health Care Monitoring Services

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RECOMMENDATION #3: Complete the ongoing provider rate structure reform initiative.

Context: In 2013, the General Assembly through the Joint Chairmen's Report required the Interagency Rates Committee (IRC) to conduct an evaluation of the rate setting process for residential child care. Throughout 2014 a number of meetings were convened with stakeholders. The process was paused with the change in administrations.

Under the Hogan Administration, DHS once again began working on developing a new rate setting methodology. The 2020 budget included funding to support an interagency agreement with the University of Maryland School of Social Work Institute for Innovation and Implementation and the Hilltop Institute at the University of Maryland Baltimore County to develop the revised process. The FY2020 SSA Budget Analysis reported that the new rate structure was expected to be developed by December 2019 and used for the first time in fiscal 2021. Delays in the process resulted in the release of a new timeline with final implementation not occurring until mid-2025.

In the meantime, provider rates continue to be set by the IRC. The IRC is supposed to take into account a program's actual costs and issue a rate based on those costs. However, in most years the Governor and legislature have artificially capped increases through language in the Budget Reconciliation and Financing Act. In the few years that rates were not capped, programs still were not able to submit their actual costs for fear that they would get a "non-preferred" status which could reduce their census.

In addition to the financial impact on providers, the lack of a revised process has prevented DHS from billing Medicaid for certain reimbursable services since 2015, which has exacerbated the placement crisis described above as providers cannot afford to keep programs open that do not cover the costs of service delivery.

Recommended Actions

First 100 Days **• Provide all Residential Child Care (RCC) and Child Placement Agency (CPA) programs with a rate increase that matches the Consumer Price Index (CPI) for January 2023 or their requested rate, whichever is higher.**

First Year **• Revise the IRC procedures to remove preferred and non-preferred status from the procedures.**

First Year • **Ensure the Quality Services Reform Initiative (QRSI) process continues without any further delay and Residential Child Care (RCC) reform launch remains on track for 2025.**

Sources & Supporting Resources

- ➔ MD General Assembly Joint Chairmen's Report, 2013
- ➔ FY2023 Budget Analysis N00B - Social Services pg. 43
- ➔ FY2020 Social Services Administration Budget Analysis
- ➔ Status and Timeline for the New Provider Rate Structure (Maryland DHS)
- ➔ Quality Service Reform Initiative Update November 2021 (UMD & Maryland DHS)
- ➔ Maryland's Children's Quality Service Reform Initiative Vision Document

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RECOMMENDATION #4: Address the child welfare staffing crisis in both public and private facilities.

Context: The FY2023 Budget Analysis for the Department of Human Services reported that there were 880 vacancies in the Department of Human Services. The Social Services Administration budget analysis reported that 340 of those vacancies were in SSA. This was an increase of more than 100 over the previous year and constituted more than 13% of all authorized positions in the agency. While recent SSA vacancy numbers have not been publicly reported, the number of vacancies in the Department of Human Services increased to 945 in October 2022. Private providers are also reporting significant staffing shortages which results in reduced capacity in their programs.

Recommended Actions

First Year • **Follow the Child Welfare League of America's recommendation to complete a workload study in order to determine LDSS staff allocations based on the work that needs to be completed rather than a number of children to be served**. DHS currently uses caseload numbers (i.e. number of kids served) when a workload measurement (i.e. intensity of caseload and the time necessary to complete the myriad of requirements) is a better determinant for identifying realistic caseload assignments. Other states that have completed workload studies found far more work than the 40 hour workweek allows

First Year • **DHS should explore strategies to reduce overly burdensome regulatory requirements while ensuring staff of private providers licensed by DHS are adequately trained.**

- ➔ Develop an incentivization program for signing bonuses and increase wages.
- ➔ DHS should work with stakeholders and providers to evaluate the proper credentials for the private child welfare workforce including the appropriateness of
  - ◆ Allowing pre-licensure social workers to perform certain duties.
  - ◆ Allowing professional counselors to perform certain duties.

- Eliminating the Residential Child and Youth Care Professional certification requirement for residential child care programs. This certification is not having the intended effect of professionalizing the workforce, and instead is placing undue costs on providers and creating barriers to care. Staff already receive the training intended by the certification program.

First Year • DHS should take action to fill the vacancies in the LDSS workforce.

- ➔ Develop an incentivization program for signing bonuses and increase wages.
- ➔ Expand opportunities for financial support to attend social work programs including the IV-E child welfare education program.
- ➔ Increase paraprofessional support positions. There is a significant need to create PINS and hire peer recovery specialists, and family support staff to facilitate parent/child visits, assist with hands-on learning for parents, and family finding.
- ➔ Hold DHS Human Resources staff accountable for filling vacancies in a timely manner so candidates can start positions in a matter of weeks, not months.
- ➔ Allow local departments to do direct recruitment and certify that candidates qualify for positions.
- ➔ Review the social work series and salaries.
  - In an effort to attract social work candidates without actually raising the salary, local departments hire at a higher step. The step that's offered has created significant disparities, especially between seasoned staff and new staff, whose salary may be higher.
  - The other impact has been on supervisors, who now have staff making higher salaries with far less longevity. The marginal pay increase for a supervisor has also left current employees disinterested in assuming far greater responsibilities and the sense of liability that comes with them.

First Term • DHS should be part of the discussions with the Department of Labor and Department of Health to expand the healthcare direct care workforce and address shortages across the spectrum.

Sources & Supporting Resources

- ➔ Department of Human Services Fiscal 2023 Budget Overview (DLS)
- ➔ FY2023 Social Services Administration - DHS Analysis (DLS)
- ➔ Spending Affordability Briefing (DLS)
- ➔ Title IV-E Education for Public Child Welfare Program (UMD - School of Social Work)
- ➔ Child Welfare League of America's Caseload Recommendation

RECOMMENDATION #5: Expand the array of evidence-based practices for children at risk of child welfare involvement and their families through Medicaid and/or Families First funding.

Context: The Family First Prevention Services Act (FFPSA or Families First) was signed into law in February of 2018. One of the major provisions of FFPSA allows states to use Title IV-E funding for prevention services--treatments that target children *and their families* with the goal of enabling children to remain safely in their homes– in addition to traditional uses of funds. The Title IV-E Clearinghouse provides ratings of the evidence-based practices allowable under FFPSA. At the end of calendar 2021, 42 programs had received a rating.

DHS submitted their Title IV-E Prevention Services Plan for Maryland in February 2020. At the time, Maryland submitted five evidence-based practices that it planned to implement and had received a rating. They included Functional Family Therapy, Multisystemic Therapy, Parent-Child Interaction Therapy, Healthy Families America and Nurse Family Partnership. DHS has also expressed interest in implementing the Nurturing Parenting Program, Family Centered Treatment, and Sobriety Treatment and Recovery Teams in FY22. However, none of these prevention services have been rolled out at scale, nor have evidence-based practices been incorporated into the Medicaid state plan amendment to meet these needs.

Recommended Actions:

First 100 Days • Prioritize implementation of the Title IV-E Prevention Services Plan for Maryland. While this requires centralized planning, the local departments should be empowered to implement the plan at the local level using local procurements.

First 100 Days • DHS should increase transparency around the funds that have been used to implement these programs by publishing data on current usage of prevention services.

First Year • DHS should expand the use of approved prevention services to serve more families in more jurisdictions.

- ➔ Increase access to prevention services by putting out RFPs for vendors to provide the services at both the state and local level.
- ➔ Expand the service line to include Family Centered Treatment, a program demonstrated to be effective in Maryland. It was in the original FFPSA plan but was taken out due to issues with the clearing house that have since been resolved.
- ➔ Explore a federally allowable braiding of funding sources including Medicaid to operationalize evidence-based practices focused on family preservation.

Sources & Supporting Resources

- ➔ MD DHS, SSA - Family First Prevention Services Act - Prevention Plan

RECOMMENDATION #6: Ensure collaboration and shared responsibility between child serving agencies is effective.

Context: Increasing specialization of government services has led to silos and disconnected services that can be inefficient or ineffective. Moreover, the distribution of responsibility and the specialization within agencies often means that no one entity is responsible for listening to and holistically responding to the needs and aspirations of children and families, the intended beneficiaries of the public investments. Children's cabinets are formal structures for convening public officials with shared responsibility for supporting children's well- being; they can highlight inequities across different communities, creating awareness and accountability to solve problems that might otherwise go unaddressed. By improving coordination, collaboration, and coherence across agencies, Children's Cabinets can deliver more effective services and support to children and families that truly meets the standard of a system of care.

Children's cabinets are formal, sustained coordinating structures composed of government leaders (and sometimes external community stakeholders) working together to advance more effective, equitable, and efficient services for children and families. While children's cabinets vary in structure, size, and authority, their purpose is to break down silos across government agencies and/ or service providers to improve outcomes for children and families. Administering government services necessarily entails some expertise and specialization; children's cabinets can advance a coherent vision for orienting all child-and-family serving programs. Fully understanding and addressing the needs of children and youth who interact with multiple government agencies requires shared information, goals, and progress metrics (Strong and Sustainable Children's Cabinets).

See also Family Investment Administration Transition Report

Recommended Actions

First 100 Days • **Reestablish the Governor's Office for Children as a stand alone office.**

- ➔ Announcement of this move should identify the importance of inter-agency collaboration and breaking through silos. Provide a leadership vision and a multi-year strategy to invest in the wellbeing of children in Maryland which includes cross-agency collaboration, stakeholder involvement, and clear lines of authority to solve problems.
- ➔ Appoint a Director of the Governor's Office for Children who has experience with the intersection of child serving systems, and expertise in leveraging Medicaid funding within those systems.
    - ◆ Empower the director to hold agency leadership accountable.
    - ◆ Provide appropriate funding so the GOC can hire staff and tap into resources to address immediate and acute needs, and implement cross-agency work.
- ➔ Order the Children's Cabinet to hold quarterly public meetings and to actively seek input from child health and welfare stakeholders and the public.
- ➔ Appoint the Lieutenant Governor as Chair of the Children's Cabinet
- ➔ Task the Children's Cabinet with ending the placement crisis (see Rec 1)
- ➔ Encourage interagency collaboration through sub cabinet meetings
- ➔ Empower stakeholder collaboration with public comment and workgroups

Sources & Supporting Resources

- ➔ Effective Financing Strategies for Systems of Care (University of South Florida)
- ➔ Strong and Sustainable Children's Cabinets (The Aspen Institute & The Forum for Youth Investment)
- ➔ MD Governor's Office of Children - Overview
- ➔ Maryland's Results for Child Well-Being, 2012 (Children's Cabinet and Governor's Office for Children 2012)
- ➔ Governor Hogan Launches New Initiatives to Maximize Resources and Results for Maryland's Children, Youth, and Families
- ➔ Rural Crisis and At Risk for Escalation Diversion Services (Rural CARES), University of Maryland School of Social Work

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RECOMMENDATION #7: Expand the use of a Certified Community Behavioral Health Clinic (CCBHC) model in Maryland.

Context: CCBHCs are 24 hour clinics that provide coordinated, comprehensive behavioral health care to children and adults regardless of ability to pay, place of residence or age. Maryland currently has five Certified Community Behavioral Health Clinics (CCBHC) operating in the state with funding from SAMHSA demonstration grants. 23 states have adopted this model.

While CCBHCs serve all ages, expansion of the model presents a timely opportunity for Maryland to improve service delivery for youth and their families. CCBHCs eliminate long waits for services–the national average is 48 days– by offering same-day access; they have the capacity to build out evidence based practices; they utilize a cost-based reimbursement payment structure which enables investment in workforce and ensures appropriately staffed clinics; they provide needs-based flexibility by reimbursing for services delivered outside the clinic setting, including in schools; and they provide more consistently high quality treatment by requiring demonstrated provider capacity to deliver a continuum of care and meet performance standards.

CCBHCs can be supported through the CCBHC Medicaid Demonstration, through SAMHSA administered CCBHC Expansion (CCBHC-E) Grants, or through independent state programs.

Recommended Actions:

First Year • **Use general funds to maintain existing CCBHC service delivery in the state if the Hogan administration ends the program by not reapplying for planning grants in 2022.**

First Year • **Explore use of Medicaid state plan amendments and waivers to implement CCBHCs without a planning grant.**

First Term • **Require BHA/Medicaid to apply for SAMHSA planning grants when available.**

Sources & Supporting Resources

- ➔ Certified Community Behavioral Health Clinics (CCBHCs) (SAMHSA)
- ➔ CCBHC Fact Sheet - December 2022
- ➔ The CCBHC Model: A Review of the Certified Community Behavioral Health Clinic Model for the Community Behavioral Health Association of Maryland (National Council for Wellbeing)

RECOMMENDATION #8: Continue the implementation of MD THINK and prioritize improvements to user experience and data reporting.

Context: At the launch of MD THINK in 2017, it was described as "a groundbreaking technology platform that will transform the state's ability to deliver vital human services." Admittedly, the systems DHS relied on were ineffective and desperately in need of replacement. However, MD THINK has been plagued by delays, cost overruns and operational glitches. CJAMS, the SSA component of MD THINK, has been plagued with issues. Caseworkers are faced with overcomplicated instructions on how to input data and the Department is not able to pull needed reports out of the system. Additionally, the promised interoperability with other state data systems never materialized.

First 100 Days • **Conduct an evaluation of the implementation and current status of MD THINK with recommendations for additional improvements.**

First Year • **Provide DHS with the appropriate financial and technical support to implement the recommendations included in the evaluation report.**

Sources & Supporting Resources

- ➔ Governor Larry Hogan Announces Launch of Groundbreaking "MD THINK" Technology Platform
- ➔ Summary of MyMDTHINK Issues (CASH Campaign of Maryland)

CRITICAL DOCUMENTS

- Interagency Plan: Developing Resources to Address the Complex Needs of Maryland Youth in Care
- HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities
    - Fiscal & Policy Note

- SB 637: Health and Health Insurance - Behavioral Health Services - Expansion (Behavioral Health System Modernization Act)
- Monthly Child Welfare Data Reports
- Report on Behavioral Health Services for Children and Young Adults
- 2021 Child Welfare System Report
- Maryland State Council on Child Abuse and Neglect Annual Report: January 1, 2020 - December 21, 2021
- Department of Human Services Child and Family Services Plan 2020-2024
- CH 407 of 2018 - Human Services - Children Receiving Child Welfare Services - Centralized Comprehensive Health Care Monitoring Program
- Kids Count Data Book for Maryland
- Youth Risk Behavior Survey Maryland State Level Data
- Maryland Children Can't Wait, Community Behavioral Health Association