Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

Behavioral Health Administration
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Deputy Secretary Behavioral Health
55 Wade Ave., Dix Bldg., SGHC

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Dear MABHA,

Please forward this to all jurisdictions. The closing date for the Telehealth Equipment Program Pilot RFP has been extended, so providers now have until April 15th to submit their proposals to their jurisdictions. Now jurisdictions should submit to BHA their 2 selected providers by May 20th, and they should include their rankings of non-selected providers in case funding becomes available for additional providers. They can email this to me at steven.whitefield@maryland.gov. Another change is that the funds will be awarded after July 1st. We are now up to 18 jurisdictions, and there is still time for additional jurisdictions to participate, so let me know if any do join. I have also provided answers to submitted questions below.

Regards,

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1. Will all equipment bought (including hot spots) be put in the name of [the provider organization] or the State of Maryland? In the name of the provider. Providers maintain ownership of smartphones and tablets, loaning them to clients via signed agreements contingent on continued enrollment with the provider. Providers will need to track the equipment, and a small percentage of the funds will need to be held in reserve for any needed equipment replacement..

2. We have a home-based intensive intervention focused on mothers with opioid/ other SUD with no MH billing attached. Is this an allowable target population? Yes.

3. Is our company financially responsible to State of Maryland for all tablets, IPhones we are not successful in retrieving? Or is it a write off? Providers are not financially responsible.

4. We have two licensed sites--one in Towson, and one in Cumberland-- who operate regional services in the Baltimore Metropolitan and Western Maryland areas. May we apply in the name of these regions rather than each single jurisdictions? Submit separate responses in each jurisdiction. Each participating jurisdiction is scoring all of the applications submitted to it and then selects 2.

5. Our Towson Office services sites in both of your jurisdictions. Can we apply as a regional provider, and, if so, what is the process of applying as a joint project, sending our information to both counties? See #4.

6. How long does this pilot last? (I could not find in our RFP). The anticipated maximum total a provider would receive is $21,750. This is determined from the calculation that the average cost per client to fund telehealth access for 1 year is $870, and with each provider funded to a target of 25 clients. The funds per provider is estimated to pay for the equipment and I year of internet access for 25 clients, but it could be that the funding for internet access does not provide exactly 1 year of access.

7. Is there a maximum number of months one can lend out a device to the client? No- see #6.

8. Knowing that we have to keep some back in reserve for loss, damage, what annual level of utilization per phone/ tablet do you expect? (e.g., 75%?, 80%? 100%?) The utilization percentage should be in the 85-95%% range but will vary depending on the number of participating clients who dropout from provider services, and how quickly another client can be identified to receive the device.

9. We are vetting this opportunity and considering the financial impacts. Please advise if there is allowance for indirect cost. If yes, what is the percentage? A pilot of this nature will require considerable staff support and we need to weigh all those factors.

There is no indirect. The hope is that for providers who participate in this pilot program the staff burden would not be too much because enough of it could fit in with client and staff supports they already have.

For their clients who are already using telehealth, because they already had a smartphone or computer, or bought one since the pandemic hit, some more than others needed support initially from staff to master the use of telehealth.

The difference for this program is that the provider will own the equipment the program's funds purchase, loans the equipment to clients, and is using the program's funds to themselves to also pay for ongoing internet access for the equipment. If a provider can incorporate this into the process of how they provide their staff smartphones and computers, and pay for their ongoing internet access, their burden would be lessened.

It is estimated that the funds available per provider for this pilot phase would only cover 25 clients per provider, and the number of providers at this time will be 2 per jurisdiction, so it only addresses the digital divide in a very small manner, but by participating it would increase by 25 a provider's clients who then can experience the benefits of telehealth.

10. Are the Baltimore City Capitation Project providers eligible to apply since their organizations are affiliated with hospitals? No. Providers affiliated with hospitals are not eligible.

11.What evidence/support would be needed to justify tablets for adults with an exception request with an appropriate rationale? Clarity on how this – smartphones vs. tablets for children/adolescents was decided would be helpful. With smartphones less expensive than tablets, from the funds a provider receives more clients may be able to participate if more smartphones are used. But tablets may have advantages for some adults, such as those with vision issues, tech challenges using a smartphone, or other rationales. For children/adolescents a tablet also can be more beneficial for their education, especially if virtual. For someone under 18 if they, parent/guardian, and the provider agree that a smartphone is fine for them, then this can also occur.

12. The RFP only notes smartphones and tablets as the use of funds. However, I was wondering if we would be able to apply for funds to be used to buy an owl camera, it's a large meeting room camera that we believe would improve our quality of group meetings. Currently our IOP groups are held with less than ten people, socially distanced and in two separate rooms. The owl camera is designed for meetings so that participants on zoom can see and hear everyone in the room. Since moving our IOP groups onto zoom, we've seen a decline in quality of the therapeutic aspect of the group since participants aren't able to properly see and hear each other on the platform, we think that the owl camera will help with that. An owl camera. An owl camera is not eligible for funding. The funding is limited for this program, with the goal of providing telehealth access to those without any, and so it is designed only for

smartphones and tablets.

13. We have developed a substantial online presence to continue to deliver services amid the pandemic. The problem has been that many of our clients do not have properly working hardware to take full advantage of our offerings. The question we have: Can we use the funding to purchase smartphones or tablets for clients who need them, and if so, do we need to maintain ownership of the equipment, keep track of its location, and assure it is returned, or can clients keep the equipment we provide them?
See #1.