Answers to Frequently Asked Questions (FAQ) about the Maryland Children's Quality Service Reform Initiative (QSRI)

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Contents

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Background, History, Terms, and Purpose

What is the history behind QSRI and why is this reform needed?

Maryland's residential child care (RCC) programs (aka group homes) are licensed primarily by the Department of Human Services, with some licensed by the Department of Juvenile Services and the Department of Health. The programs are contracted for services by the Department of Human Services and Department of Juvenile Services. In 2011, the U.S. Department of Health & Human Services informed the State of Maryland it "cannot determine" whether Medicaid claims for RCC services under the Residential Rehabilitation Option of the Medicaid State Plan complied with requirements. It recommended that Maryland define residential rehabilitation services, define the necessary documentation requirements for each service, and adjust its reimbursement methodology if needed. In 2013, the Maryland General Assembly issued a report, followed by a report by the Maryland Interagency Rates Committee, which recommended development of a new rate structure for RCCs. In 2015, Maryland removed RCCs and treatment foster care programs from its Medicaid State Plan. In 2018, the current work of the Children's Quality Service Reform Initiative (QSRI) began, building on findings and work from the prior years.

For more than a decade, Maryland has been reducing the number of children in out-of-home placements as well as those placed in RCC programs, commonly referred to as group homes. However, Maryland continues to have high numbers of children placed in non-family settings. The placement process is highly variable and relies heavily on the opinions and expertise of LDSS staff members, as well as the availability of placements and the responsiveness of providers. There is no consistent, standardized approach to referring a child to an RCC. There is still a heavy reliance on the use of one-on-ones in RCCs, with the most frequently requested service for "supervision/monitoring."

Maryland's youth, families, providers, and agencies currently experience inconsistent referrals to RCCs and child placement agencies (CPAs), sometimes just based on the lack of an available family foster home bed. There are long lengths of stay in residential settings, hospital overstays, and vacancies and high rates of turnover among RCC staff. There is significant variation in rates for different programs without consistent program information, unknown outcomes data, and rates for services do not always align with service delivery expectations. Additionally, Maryland is not claiming federal funds for reimbursement through Medicaid and is not able to maximize reimbursement under Title IV-E.

What is QSRI? Is it just about new rates?

QSRI is not just about new rates. QSRI is about developing new rates for RCCs, CPAs, and some evidence-based practices (EBPs)
AND

- Developing classes of residential interventions with defined medical necessity criteria, consistent and transparent access and referral pathways, and a CQI overlay.
- Developing rates for services that:
    - Compensate the workforce with living and competitive wages consistent with their training and expertise
    - Reflect newly defined staffing ratios that support child and worker safety and well-being and an intensity of service provision not available in a family setting
    - Are consistent across programs and agencies

- Designing an approach to be able to leverage Medicaid and Title IV-E funds with classes of rates for direct care and clinical services, with the ability to integrate services into the larger Public Behavioral Health Service Array.
- Developing clear expectations and accountability for populations of children served, rates paid, and outcomes achieved.
- Designing a service model that can support shortened lengths of stay and improved outcomes for children and youth and their families while children are in the least restrictive setting.
- Aligning and integrating the model with the federal Child Care Institution (CCI) requirements, including Qualified Residential Treatment Programs (QRTPs).

What do we mean by *residential interventions* and how is that different from an RCC or group home?

Consistent with current national best practices, *residential intervention* refers to a type of out-of-home placement that provides the necessary treatment services and supports to address a clinical and/or behavioral need of a child that cannot be met in a family setting. A new residential intervention service will include comprehensive, consistent service descriptions, medical necessity criteria (MNC), and provider qualifications. In other states, *residential intervention* is inclusive of PRTF/RTCs and psychiatric hospitals. However, Maryland is using the term to represent interventions that are less intensive and restrictive than a PRTF or psychiatric hospital. Maryland is *not* including PRTF/RTCs in its definition of residential interventions.

QSRI is not changing the licensing requirements or process in Maryland, so the term *RCC* is unchanged. *Group home* is an informal term used to refer to the type of congregate care setting that most RCCs provide. The term *residential intervention* is being used as part of the QSRI work to highlight the treatment element of the setting. During the transition to the new rate structure and approach, it is possible that some RCCs will not become residential interventions if they do not provide any of the clinical or treatment services or supports.

New RCC Classes and Rate Structure

What is the new rate model for RCCs?

The State is establishing tiers or classes of rates for RCC programs. There will be direct care and clinical care rates for each class of RCC.

The direct care rates are based on the costs to provide high quality care 24 hours per day, 7 days per week for children and youth in the program. These costs are based on staff qualifications, staff-to-child ratios during awake and asleep hours, supervision, housing, food, security, transportation, recreation, clothing, activities of daily living, and more.

The clinical care rates are based on the costs to provide high quality clinical, behavioral, and therapeutic services, supports, and interventions to the children being served and, as appropriate, their families, with the requisite intensity based on the needs of the children and youth.

What is the difference between the current rate method and the proposed approach?

Current Rate Method	Proposed Rate Method
Uses an annual, individual rate-setting methodology established in 1999	Moves to a class-based model for rates with direct care and clinical care rates
Requires providers to submit an annual budget package to the Interagency Rates Committee (IRC) for each program	Providers will not have annual budget submissions
Designates providers as preferred or non-preferred	No designation as preferred or non-preferred
Uses a Level of Intensity model	Does not use Levels of Intensity. Uses classes and associated medical necessity criteria
Typically, rates are based on prior years' rates, with increases to rates only as approved and as permissible by the State budget	Rates are set ahead of time and are adjusted (likely every 2-3 years) with consideration for inflation and other changes. Rates are based on staffing ratios, qualifications of staff, size of program, and population served.
Considerable variation within categories of programs, even within preferred providers	Providers will select their classes based on their staffing, size, expertise, and program model. All providers within a class will have the same rate.

How will each RCC receive a rate?

Each class of program will have an established service description that includes minimum staffing requirements and service expectations.

- To be approved to receive a rate, the Maryland-licensed RCC will need to submit an application to the State that is complete, accurate, and includes all supporting documentation required to demonstrate that the RCC meets the requirements for the class. Each program location will require its own class designation.
- RCCs must agree to continue to meet those requirements and serve children and youth who meet the criteria for that class.

- RCC programs will be expected to customize their models to the specific population of children and youth they serve while meeting or exceeding minimum standards for the class.
- The State or its designee will require the RCC to confirm its class designation annually and, in so doing, will agree to continue to meet all requirements. Providers may request to change their designation annually or more frequently at the discretion of the State, consistent with the reconsideration and/or modification process.
- The State will require providers to enter into a contract to provide services under the class and may require the RCC to enroll or maintain enrollment as a provider in Maryland's Medicaid program.

For FY25: All RCC providers seeking a rate for FY2025 must submit all forms and documents as outlined in the *Interagency Rates Committee (IRC) FY 2025 Residential Child Care/Child Placement Agency Provider Instructions and* the *Class Rate Application Addendum*.

Why do RCC providers need to submit the full FY2025 RCC application and workbook *and* the Class Rate Application Addendum for FY25?

The current regulations in COMAR 14.31.04 require the specific forms that are included in the FY2025 RCC application and workbook to be completed. COMAR 14.31.04 is being updated but, until the new regulations are finalized and in effect, the State is unable to issue rates based only on the *Class Rate Application Addendum*.

Will RCC providers receive an individual rate or a class rate for FY25?

The goal is for all RCC programs to receive a class rate effective July 1, 2024. However, if the regulations are not finalized and in effect, individual program rates will be provided and the class rates will be provided as soon as the regulations are in effect. All rate letters will go out by June 15, 2024. Updated letters will go out if needed.

How many RCC classes are there and what are the differences between the classes?

There are six classes of residential interventions (Classes 1-6) and two classes of "legacy" RCC providers (Classes 0 & 99), for a total of eight classes for FY25.

All classes are required to:

- Continue to meet all requirements for the license (statutory, regulatory, and contractual);
- Participate in the data collection and reporting process as specified by the State, which includes providing monthly performance data to DHS, DJS, and/or their contracted partner on the measures and in the format specified; and
- Maintain at least two awake staff always.

The description of the classes and the minimum requirements for each are found in Table 1.

Table 1: FY25 RCC Class Descriptions and Minimum Requirements

Class	Direct Care Staffing Ratio (Staff : Youth)		Additional Requirements (In addition to standard requirements of meeting all statutory, regulatory, and contractual requirements of license; participate in data collection and reporting process; and maintain at least two awake staff always)
	Awake	Asleep	
0: Pre-QRTP	1:6	1:7	N/A**
99: IDD Legacy	1:3	1:4	N/A**
1: Serve Youth with Significant Behavioral Health Service Needs (Class 1 or 1b)	1:4	1:5	• Serve children with significant behavioral health service needs • 1:10 ratio of care manager to youth • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Meet Maryland's requirements for QRTPs^
2: Serve Youth with Intensive or Specialty Behavioral Health Service Needs (Class 2 or 2b)	1:3	1:4	• Serve children with intensive and/or specialty behavioral health service needs • Maintain 1 floater, direct care staff outside of ratio during awake hours • 1:8 ratio of care manager to youth • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Clinical/behavioral health supervisors have at least 2 years of experience providing similar services and/or working with this population (preferred for all clinicians) • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment • Meet Maryland's requirements for QRTPs^
3: Serve Youth with High Intensity I/DD Service Needs (No Behavioral Health Services)	1:1	1:1	• Serve children with high intensity intellectual and/or developmental disability service needs • Maintain 1 floater, direct care staff outside of ratio during awake hours • Provide transportation to any clinical or behavioral health services required (not required to provide the services directly) • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment
4: Serve Youth Needing High Intensity Medically Fragile Services	1:1	1:1	• Serve children with high intensity medically fragile service needs • 24/7 nursing services provided to meet the physical health needs of children and youth served • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment • Provide transportation to any clinical or behavioral health services required (not required to provide the services directly)

Class	Direct Care Staffing Ratio (Staff : Youth)		Additional Requirements (In addition to standard requirements of meeting all statutory, regulatory, and contractual requirements of license; participate in data collection and reporting process; and maintain at least two awake staff always)
	Awake	Asleep	
5: Serve Youth Who Have Experienced/At-Risk for Commercial Sexual Exploitation	1:1	1:1	• Serve children who have experienced or are at-risk for experiencing commercial sexual exploitation (CSE) or human trafficking, as screened or assessed with State-identified tools, who have significant or intensive behavioral health service needs • Maintain 1 floater, direct care staff outside of ratio always • 24/7 nursing services provided to meet the physical health needs of children and youth served • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment • Must document that the youth have experienced CSE or are at-risk for CSE based on State-approved tool • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Clinical/behavioral health supervisors have at least 2 years of experience providing similar services and/or working with this population (preferred for all clinicians)
6: Serve Youth with the Highest Intensity Behavioral Health and Intensive I/DD Service Needs	2:1	1:1	• Serve children with the highest intensity behavioral health service needs and co-occurring intensive intellectual and/or developmental disability service needs • Maintain 1 floater, direct care staff outside of ratio during awake hours • 1:8 ratio of care manager to youth • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Clinical/behavioral health supervisors have at least 2 years of experience providing similar services and/or working with this population (preferred for all clinicians) • Meet Maryland's requirements for QRTPs
^To receive the rate for this class, the provider will need to document that they meet all QRTP requirements except for any for which they request a temporary deferral. Temporary deferrals may only be requested for nursing staff and accreditation. Providers must demonstrate that they are working toward and expect to be eligible to be certified as a QRTP by the end of SFY25. Providers may be required to provide proof of those efforts periodically during the year. Providers applying for a Class 6 rate must be eligible to be a Maryland QRTP by 6/30/24.			
**Expected to provide transportation to any clinical or behavioral health services required, although not required to provide the services directly.			

What are the FY25 RCC Class rates?

Table 2: FY25 RCC Class Rates

Class & Description		Total Per Diem Rate (FY25)
0: Pre-QRTP		$433.46
99: Intellectual/Developmental Disability (I/DD) Legacy Program		$606.65
1: Serve Youth with Significant Behavioral Health Service Needs	Class 1 (6 or more beds)	$739.88
	Class 1b (5 or fewer beds)	$808.18
2: Serve Youth with Intensive or Specialty Behavioral Health Service Needs	Class 2 (6 or more beds)	$892.63
	Class 2b (5 or fewer beds)	$986.54
3: Serve Youth with High Intensity Intellectual/Developmental Disability (I/DD) Service Needs (No Behavioral Health Services)		$1,313.75
4: Serve Youth Needing High Intensity Medically Fragile Services		$1,581.55
5: Serve Youth Who Have Experienced/At-Risk for Commercial Sexual Exploitation		$1,996.66
6: Serve Youth with the Highest Intensity Behavioral Health and Intensive Intellectual/Developmental Disability (I/DD) Service Needs		$2,099.80

What is the cost basis for the rates for each class?

The two main drivers of costs are personnel and operating costs. Even though programs within the same class may serve children with different needs, the costs are similar regarding wages, ratios, training, and supervision. Programs in classes 3-6 have additional personnel and/or operating costs associated with supervision, security, and care management.

Rates were developed by Public Consulting Group (PCG) in collaboration with the State Agencies and QSRI Workgroup. PCG used a pro forma modeling approach to develop the class rates; documentation of the rate methodology is available upon request to the Social Services Administration, Department of Human Services. The rates for the Pre-QRTP and Intellectual/Developmental Disability (I/DD) Legacy Program Classes are based on the direct care costs of current programs that have indicated they are unlikely to meet QRTP requirements and do not provide clinical behavioral health services. Rates for Classes 1 and 2 are based on the costs of QRTPs and the staffing requirements outlined. Rates for Classes 3-6 are based on existing operating costs and expectations for the programs.

Will rates be updated in the future? How will we know if they are sufficient?

The State Agencies will be working with PCG and Innovations Institute to collect data during FY25 to identify the impact of the rates. The State is optimistic that providers will utilize the generous rates flexibly to meet the needs of the children in their care, recognizing that some children need more support and others need less and programs can budget accordingly. If there are costs that were not accounted for because they were paid outside of the provider submitted MSDE budgets or the historical 1:1 usage data, that will be reviewed and could be part of a future year adjustment if necessary.

Are there geographic differences in the rates?

For FY25, there are no geographic differences in the rates. PCG raised all rates to enable them to be competitive in the DC market and the new structure and higher rates are anticipated to support providers across Maryland. However, rates will be monitored in FY25 to determine if any adjustments are needed in the model.

Do the rates address higher compensation needed to recruit and retain the direct care workforce?

Rates across all classes are very generous and give providers the room and flexibility to pay workers what they need to pay, including any sign-on or retention bonuses.

Can providers apply to be in multiple classes?

Each program site will have a class. Programs with multiple sites may have multiple classes, depending on their program model. Providers with questions about what constitutes a separate site should contact MSDE.

What happens if a child needs services that are outside of the rate?

The class rate is comprehensive and covers all room, board, maintenance, recreational, and daily living costs to support the child as well as all behavioral health clinical or therapeutic services. Costs covered by the Managed Care Organizations (MCOs) under the Maryland Medical Assistance Program are not included in this rate. Specialized assessment or diagnostic services may be covered outside of the rate, consistent with eligibility for reimbursement and with prior approval from the child's placing agency. The child's MCO will continue to be responsible for covering the physical health, dental care, and primary behavioral health needs of the child, along with authorized speech, physical, or occupational therapies. There may be rare exceptions when the child's placing agency will approve reimbursement to the provider for costs outside of the rate, such as transportation costs associated with highly specialized treatment for a particular condition or to meet the cultural or linguistic needs of the child. The State will not pay for one-on-one services for children who have been admitted into the RCC, except in those settings where the one-on-one add-on rate is permitted and only with prior approval from the placing agency. The provider will be expected to manage individualized services and supports to children served using the rate provided.

The forms and processes for requesting add-on rates are under development. The 1:1 staff and 1:1 nurse request forms and processes will be available prior to July 1, 2024. The EBP add-on application will be forthcoming, with a rolling application process through FY25.

The rates for Classes 0, 99, 3, and 4 do *not* include any behavioral health services. Children placed in programs receiving these rates should receive behavioral health services, as needed and authorized, through the public behavioral health system (Medicaid reimbursement). The RCC provider is responsible for coordinating and transportation to and from the appointments but is not responsible for paying for the behavioral health services eligible for Medicaid reimbursement.

What does it mean to maintain 2 awake staff always?

All programs, regardless of their size, must always have 2 awake staff, regardless of whether the children and youth in the program are awake. Programs with few beds may need to have additional awake staff outside of the mandatory ratio in order to meet this requirement. For example, a program with 3 beds that has a 1:3 ratio will need to have 2 awake staff. This has been accounted for in the rates and is why there is a differential between Classes 1 and 1b and Classes 2 and 2b.

What does it mean to have 1 floater, direct care staff in Classes 2, 3, 5, & 6?

Programs with this requirement must have a direct care staff member who is present in addition to any of the direct care staff required as part of the ratio. In other words, this

person is "outside of ratio." This person can provide short-term 1:1 supports, assist in de-escalating a crisis, provide additional supervision, or otherwise assist the rest of the staff.

How does the Class 4 rate account for the high costs of youth who need high intensity medically fragile services?

The Class 4 rate is based on the MSDE model budgets and then modified based on conversations with the State Agencies and providers; 1:1 nursing was added as an option to support Class 4 in case of need. The rate for Class 4 is meant to be high to accommodate high staff levels. The rate includes all the standard non-behavioral health costs, 1:1 direct care ratio, heavy dosage of nursing (almost 2:1), all backup costs for supervisors, CQI, housekeeping and maintenance higher than others, and a high management rate. It includes ample operating costs for medical needs youth have in that setting.

What are the add-on rates and who can use them?

Table 3: FY25 RCC Add-On Rates

Type of Add-On Rate	FY25 Rate	Eligible Class	
1:1 Staffing	$30.15/hour	0	Pre-QRTP (No clinical Services)
		99	Intellectual/Developmental Disability (I/DD) Legacy Program (No Clinical Services)
		1	Serve Youth with Significant Behavioral Health Service Needs (6+ Beds)
		1b	Serve Youth with Significant Behavioral Health Service Needs (5 or Fewer Beds)
		2	Serve Youth with Intensive or Specialty Behavioral Health Service Needs (6+ Beds)
		2b	Serve Youth with Intensive or Specialty Behavioral Health Service Needs (5 or Fewer Beds)
1:1 Nursing	$85.57/hour	4	Serve Youth Needing High Intensity Medically Fragile Services
Evidence-Based Practice (EBP)	$23.54/day	1	Serve Youth with Significant Behavioral Health Service Needs (6+ Beds)
		1b	Serve Youth with Significant Behavioral Health Service Needs (5 or Fewer Beds)
		2	Serve Youth with Intensive or Specialty Behavioral Health Service Needs (6+ Beds)
		2b	Serve Youth with Intensive or Specialty Behavioral Health Service Needs (5 or Fewer Beds)

When will the new rates take effect? Will providers submit budgets to the Interagency Rates Committee for July 1, 2024?

The new rates for RCCs are expected to take effect on July 1, 2024, if necessary regulatory changes are effective. If regulatory changes are pending, RCCs will receive an individual program rate and receive an updated letter with their class rate once the regulations are effective. CPAs will continue to submit budgets to the IRC for State Fiscal Year 2025; new rates for CPAs are not expected until July 1, 2025.

Is there an opportunity for providers or the state to expand or increase services?

The contracting entities have the right to expand services based on needs and trends they see. QSRI and rate reform is about creating transparent classes of programs to align children with the most appropriate and effective treatment intervention. Each program site

will be receiving a rate and contracting entities can reach out and solicit to procure additional services as needed. Additionally, because of the average population numbers used to create the rates, the rates do include elements that were not included historically in individual provider rates. The addition of these elements provides room for providers to transition programs to another location if desired. If providers are modifying their program during the year, they will submit a request for a reconsideration and/or modification. If a program only increases the number of beds at the program site during the year, the rate will stay the same unless the class changes to account based on the number of beds (i.e., a Class 1b program becomes a Class 1 program due to the number of beds).

Medicaid Reimbursement

What will the role of the Administrative Service Organization (ASO) be in authorizing or paying for services?

The Administrative Service Organization (ASO)[1] will support RCC providers to enroll as Maryland Medicaid providers and will provide associated training and technical assistance to providers. The ASO will review and approve or deny all authorization requests (initial and concurrent) for children to be served in a residential intervention. Any appeals will follow the existing appeals process for denials. The ASO will provide technical assistance to support the authorization process.

It is anticipated that the ASO will reimburse providers based on services provided beginning July 1, 2025. Additional detail about the role of the ASO and specific processes will be forthcoming in FY25.

When is the Medicaid State Plan expected to be updated and when will providers be required to start requesting authorizations and payment through the ASO?

From July 1, 2024-June 30, 2025, providers will bill their contracted agencies—the Department of Human Services or the Department of Juvenile Services—for their services as they do currently and will be reimbursed using their FY2025 rates.

The new ASO is expected to start on January 1, 2025. Providers will be supported to enroll with the ASO from January 1, 2025-June 30, 2025. The Medicaid State Plan is expected to be updated to include residential interventions in time for providers to begin billing the ASO on July 1, 2025.

Will providers have to bill DHS or DJS *and* the ASO/Medicaid?

No, once the ASO is reimbursing providers (expected July 1, 2025), providers will submit one claim to the ASO. The ASO will manage the reimbursement process, including working with the Department of Health to receive payment from DHS and DJS for any costs not eligible for Medicaid reimbursement. DHS will be responsible for obtaining reimbursement from the federal government for Title IV-E reimbursable costs.

[1] Maryland's current ASO is Optum Maryland. The Maryland Department of Health issued a Request for Proposal for an ASO for Maryland's Public Behavioral Health System on 1/10/23: MDH OCMP # 23-19761. Page 91 of the RFP references the role of the ASO in supporting residential intervention services.

Clinical & Quality Oversight

How will a child be authorized for services?

The exact process is still being determined. However, every child recommended for a residential intervention will be required to have documentation that meets the requirements specified in the medical necessity criteria (MNC). Those documents will be submitted to the ASO for review and authorization. The ASO will communicate with the placing agency regarding the authorization (initial and concurrent) and will work with both the placing agency and residential intervention on transition planning.

In FY25, MNC will be available to use as a guide but will not be applied by the ASO or other entity in a formal process. This will enable providers and placing agencies to work collaboratively with youth and families to implement the new class rate approach and ensure readiness for Medicaid claiming in FY26.

What happens if a child does not meet medical necessity criteria for the service?

If the ASO determines that the child does not require the intensity of clinical treatment and/or supervision provided in the residential intervention, the ASO will work with the placing agency to ensure a comprehensive understanding of the determination and will assist with identifying community-based services that meet the child's needs. If the ASO determines that a more restrictive and intensive level of service is needed, the ASO will assist the placing agency with identifying an appropriate treatment intervention.

If the child is in the care and custody of DHS or DJS, those agencies may determine that a child is appropriate to be served in the residential intervention, even if the ASO denies the request. If this occurs, the costs will not be charged to Medicaid and both the clinical and direct care costs will be the responsibility of the placing agency. This determination will be made by the Secretary of DHS or DJS or their designee.

Right now, children with a variety of needs may be placed in the same RCC. Will the placing agency work with providers to assist with placing children based on classes?

Yes, while placing agencies always try to place appropriately, there can be children with very different needs in the same placement. Once providers select their class, the placing agencies will be able to use that class description and MNC to help streamline the process. Implementation of any model to scale can take many years so Maryland expects it will take several years for new processes to be fully implemented.

Will all RCCs be required to be a QRTP?

No. To receive the rate for Classes 1 and 2, providers need to document that they meet all QRTP requirements except for any for which they request a temporary deferral. Temporary deferrals may only be requested for nursing staff and accreditation requirements. Providers must demonstrate that they are working toward and expect to be eligible to be certified as a QRTP by the end of SFY25. Providers may be required to provide proof of those efforts periodically during the year. Providers applying for a Class 6 rate must be eligible to be a Maryland QRTP by June 30, 2024. All providers are encouraged to become QRTPs.

If a program is already a QRTP, will they need to re-apply?

No, the provider will just note that they are already a QRTP on the rate addendum form.

Are there preferred accrediting bodies for QRTPs?

The three accrediting bodies identified by the U.S. Department of Health & Human Services are the same three that Maryland accepts: CARF, COA, and The Joint Commission. There is no preference for one over the other.

If a child is recommended for a QRTP, what is the role of the Qualified Individual in the authorization process?

This process is still being determined. However, the Qualified Individual would continue to have responsibilities in accordance with federal requirements and this review would occur prior to or simultaneously with the ASO review.

What is the expected length of stay in a residential intervention?

Most children and youth would have an expected length of stay of 5-6 months. The initial authorization period will be 90 days. The first concurrent review will be for an additional 90 days, with subsequent concurrent reviews every 30 days for single month extensions of the authorization. Children and youth served in a diagnostic program would have an expected length of stay of up to 90 days, with a concurrent review occurring at 60 days and every 30 days after. These are proposed criteria only and will be finalized prior to implementation.

What happens if a child with Medicaid wants to receive services through a residential intervention and they are not in the care and custody of the state agency?

Based on experiences in other states, Maryland expects that this would not occur often. Most children and youth who are served in residential interventions have a combination of behavioral health needs and involvement with public child- and family-serving agencies that necessitate a placement in this type of treatment setting. However, once the Medicaid State Plan is approved, if a child meets medical necessity criteria for this service, it is the least restrictive and most appropriate intervention, and the family consents to care, they would be permitted to be served in a residential intervention. The State has not yet determined who would be responsible for paying for the direct care portion of the rate.

What type of data will be collected and how will it be reported?

Providers will be expected to provide data at least quarterly to DHS and DJS or their designee, which will be reviewed and reported. The data shared will be modeled on the type of data collected and associated process for collection and reporting in place for evidence-based practices such as Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). Data will support ongoing quality improvement processes at the provider, jurisdictional, state, and ASO levels. The rates for the RCCs include costs for a part-time quality assurance coordinator to support data collection and, as appropriate, fidelity monitoring.

Will providers be required to provide an evidence-based practice (EBP)? How will it be reimbursed?

Providers in Classes 1 and 2 will have the option to use an EBP in their clinical practices and receive an add-on rate as compensation. Classes 3 and 4 are not expected to provide clinical behavioral health services and Classes 5 and 6 have been structured to incorporate the costs of an EBP being provided through clinical practice. Therefore, providers in

Classes 3-6 will not be eligible for the EBP add-on rate. Pre-QRTP and I/DD Legacy Program Providers also are not eligible for the EBP add-on rate.

To receive the EBP add-on rate, the Class 1 or 2 RCC must apply and be approved by DHS, DJS, or their designee to receive it. Currently, the EBPs expected to be eligible for reimbursement through the add-on rate are Aggression Replacement Training (ART), Dialectical Behavior Therapy (DBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The FY25 list of EBPs will be finalized and information on each EBP will be shared by the State Agencies prior to July 1, 2024. Providers must agree to provide the EBP to all youth in their program unless documented that it is clinically contrary to the treatment and care of that youth.

The provider will receive the EBP rate for all children served in the program during FY25. If approval for the EBP add-on rate occurs after the start of FY25, the provider will be reimbursed with the additional rate for services provided after the date of approval. The provider must notify their contracting agency(ies) within 14 business days if they will be unable to provide the EBP for greater than 30 days; the provider will no longer receive the EBP add-on rate after this notification.

The application to receive an EBP add-on rate is separate from the FY25 Class Rate application, and the application process will be rolling.

Why can't RCC providers request an EBP add-on rate for a different EBP?

The selected EBPs were chosen as the only EBPs identified in the peer-reviewed literature, gray literature, and Clearinghouses that have shown evidence as a *clinical, behavioral health* intervention provided directly to a child or youth *in a residential setting.* RCC providers are encouraged to use EBPs and promising practices across their milieu, but the add-on rate is specifically for clinical, behavioral health interventions, not those practices provided across the setting.

Statutory & Regulatory Changes

Will there be statutory changes to implement QSRI?

At the moment, there are no statutory changes planned.

Will there be regulatory changes to implement QSRI?

Yes, the State anticipates making regulatory changes to update COMAR to align with the revised rate-setting process. These regulations will be submitted in Winter 2024.

What is the timing of submission of needed Medicaid State Plan Amendments and how does that relate to submission of proposed COMAR revisions?

The Medicaid State Plan Amendment (SPA) will be drafted during the spring and summer of 2024 along with proposed COMAR revisions impacting MDOH. Draft regulations and the draft SPA will be shared by late summer or early fall 2024 for promulgation and submission, respectively.

Terms Used

"**Administrative Service Organization**" or ASO means the entity under contract with the Maryland Department of Health to provide administrative services to operate the Maryland Public Behavioral Health System.[2]

"**Child Placement Agency**" or CPA means a privately incorporated organization that is licensed by the Department of Human Services to receive children for placement into foster homes, adoptive homes, or independent living preparations.[3] Only CPAs that provide treatment foster care and/or independent living are impacted by the rate reform process.

"**Concurrent review**" means a periodic reauthorization of continued medical eligibility for the level of services provided, which allows for close monitoring of the participant's progress, treatment goals, and objectives.[4]

"**Evidence-based practice**" or EBP means a service, practice, or intervention that has been rated or assessed:

- By the California Evidence-Based Clearinghouse for Child Welfare as *Promising Research Evidence, Supported by Research Evidence,* or *Well-Supported by Research Evidence;* and/or
- By the Title IV-E Prevention Services Clearinghouse as *Promising, Supported,* or *Well-Supported.*

"**Medically necessary**" means that the service or benefit is: (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; (b) Consistent with current accepted standards of good medical practice; (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and (d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.[4]

"**Medical necessity criteria**" or MNC means a set of qualifications to determine that the service is medically necessary.

"**Qualified Residential Treatment Program**" or QRTP is a type of child care institution that meets the requirements outlined in the Family First Prevention Services Act (FFPSA), contained within the Bipartisan Budget Act of 2018 (PL 115-123).[5] Maryland has established additional requirements and specifications for providers to be approved as a QRTP.

"**Residential Intervention**" means a type of Residential Child Care Program that provides the necessary treatment services and supports to address a clinical and/or behavioral need

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[2] Code of Maryland Annotated Regulations (COMAR) 10.09.06.02 and 10.09.80.01.

[3] Code of Maryland Annotated Regulations (COMAR) 07.05.01.02.

[4] Maryland Department of Health. (2022). *Appendix A1: Maryland Medicaid Definitions for Parity Analysis.* Available from: https://health.maryland.gov/mmcp/Documents/Parity/2022/Appendix%20A%20Final%20Combined%20Files.pdf

[5] See also ACYF-CB-IM-18-02, Attachment C for additional information about Federal Financial Participation for Children Placed in Child Care Institutions, including QRTPs. Requests for Maryland's QRTP application may be sent to quality.residential@maryland.gov or irc.rates@maryland.gov.

of a child that cannot be met in a family setting due to the intensity of the service provision and the supervision required to ensure the safety and well-being of the child.

"**Residential Child Care Program**" or RCC means an entity that provides for children 24-hour per day care within a structured set of services and activities that are designed to achieve specific objectives relative to the needs of the children served and that include the provision of food, clothing, shelter, education, social services, health, mental health, recreation, or any combination of these services and activities. RCC includes a program licensed by the Maryland Departments of Health, Human Services, or Juvenile Services and subject to the licensing rules under COMAR 14.31.05.

"**Primary Mental Health Services**" means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referral for additional services as deemed medically necessary by a primary care provider.[6]

"**Psychiatric Residential Treatment Facility**" or PRTF means any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit). The facility must be accredited by The Joint Commission (formerly JCAHO) or any other accrediting organization with comparable standards recognized by the State. PRTFs must also meet the requirements in §441.151 through 441.182 of the CFR. The regulatory authority for PRTFs includes Section 1864(a) of the Social Security Act (the Act), which authorizes the Secretary to enter into an agreement with the State. Authority also includes Section 1902(a)(9)(A), which authorizes the state agency or other appropriate medical agency, to be responsible for establishing and maintaining health standards, and Section 1902(a)(33)(B), licensing requirement.[7]

[6] Code of Maryland Annotated Regulations (COMAR) 10.67.01.01.

[7] See Centers for Medicare & Medicaid Services (CMS). (2023). *Psychiatric Residential Treatment Facility Providers.* Available from https://www.cms.gov/medicare/health-safety-standards/certification-compliance/psychiatric-residential-treatment-facility-providers and CMS. (n.d.). *What is a PRTF?* Available from https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/whatisaprtf.pdf