Quality Service Reform Initiative (QSRI)Update

IRC Provider Meeting

November 2022

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Integrating Systems • Improving Outcomes

Providers, public agencies, families, and other stakeholders have said problems with the current residential child care system include:

- Inconsistent referral and acceptance practices
- Long lengths of stay and hospital overstays
- Unknown outcomes data
- Not leveraging federal funds for reimbursement.
- Rates for services do not always align with service delivery expectations.

What are we doing with the Quality Service Reform Initiative (QSRI)?

- Developing **classes of residential interventions** with **defined medical necessity criteria**, consistent and transparent access and **referral pathways**, and a **CQI** overlay.
- Leveraging **Medicaid and Title IV-E** funds to support new rates that are based on classes of direct care and clinical services.
- Developing **clear expectations and accountability** for populations of children served, rates paid, and outcomes achieved.
- **Shortening lengths of stay** and ensuring children are in the **least restrictive** setting to reduce bottlenecking and improve outcomes.

We also need to increase home- and community-based services and availability of family-based settings for care. This is not the focus of QSRI but is critical to its success.

What are the opportunities to do things differently? What are Maryland's Interruption Points?

- Referral & Services Pathways
- Communication between Agencies and Providers
- Using Data to Inform Decision-Making
- Changing Payment Structures to Support Consistency and Transparency
- Focusing on the Clinical and Behavioral Needs of the Child

How often are activities and steps in the process viewed as **pro forma** in a pre-ordained process? How often are the same processes implemented—**consistently and transparently**—across agencies and jurisdictions? How often are **teams**-including the child and family-genuinely part of the decision-making? How often are **decisions driven** by fear or a need to be in compliance?

Proposed New Rate Methodology

- Uses the **framework of the existing IRC process** as a foundation for the cost components but it **moves AWAY from individual rates** based on individual costs
- Establishes **direct care rates and clinical care rates**
  - Direct Care Rate: A bundled or comprehensive rate to cover operating and other costs related to the daily direct care of the children, including food, clothing, transportation, utilities, rent/mortgages, socialization activities, and general supervision.
  - Clinical Care Rate: A bundled or comprehensive rate for the rehabilitative services provided to the child, based on documented need, according to clinical and therapeutic service specifications and provider qualifications. Each clinical care rate class will include a certain volume of individual, family, and group clinical or behavioral interventions during the day or week.
- **Establishes bundled classes**: Groups or tiers of programs based on similar costs or characteristics. The costs are bundled. Each program will have an assigned class for its direct care rate and for its clinical care rate. Rates will be reviewed and a new base rate will be established, as appropriate, every 2-3 years.

Maryland's Model Continuum of Residential Services for Children and Youth*

Home- and Community-Based Services (HCBS)

Services provided in a manner that enable the child to remain with or return to the family whenever possible. Includes individual, family, and group therapies, school-based interventions, medication management, intensive in-home services, mobile crisis response services, peer support, and respite care.
HCBS should be the service default service setting.

Family Foster Home (incl. kin, guardianship, pre-adoptive) & Independent Living Programs

Short-term care and supportive services to children who are unable to live at home because of child maltreatment or ongoing safety or supervision needs. Also includes private independent living programs for youth ages 16-20 in foster care.

Treatment Foster Care

Short-term placement to provide behavioral interventions and treatment in a stable, family-like setting. Developmental and/or therapeutic treatment needs exceed what can be provided in a regular foster home but whose needs can still be met in a home-like environment.

Residential Interventions

Structured, 24-hour group care treatment setting for children with serious behavioral health needs. Appropriate for children who experience episodes of behavior in home, school and/or community interfering with ability to function in multiple areas due to clinical needs. May specialize to serve particular populations of youth (e.g. youth who meet these criteria *and* are pregnant/parenting, medically fragile, or demonstrates sexually inappropriate behaviors). May include Qualified Residential Treatment Programs (QRTPs) and/or other federal Child Care Institution Requirements.

Psychiatric Residential Treatment Facility (PRTF; known in Maryland as an RTC)

Structured inpatient setting for individuals under age 21 with SED and/or long-term psychiatric illness who require ongoing, active treatment that must be provided on an inpatient basis under the direction of a physician. The youth demonstrates clinical evidence of a serious emotional disorder and exhibits significant impairment in functioning, representing potential serious harm to self or others.

Hospital Setting

Inpatient setting for acute behavioral health needs that cannot be met in any other setting, even with individualized interventions, including when the individual poses an immediate threat to self or others. May include short- or long- term stays for diagnosis, assessment, and treatment and medical detox when those needs cannot be met in any other setting.

Has DSM-5 Diagnosis and requires clinical intervention that cannot be provided within a family setting due to the intensity of the treatment and 24/7 supervision requirements, which cannot be replicated in a family setting. Provides trauma-responsive care, includes family participation, has required licensing & accreditation, and provides 24/7 access to nursing/medical staff.

* This continuum does not include every possible type of setting, including those that are primarily for public safety needs. Children and youth should not be required to progress up or down the continuum in a linear fashion. Intensity of service need does not always equate to restrictiveness of care and children and youth should receive services and supports in the least restrictive, most home-like environment as possible to meet their individualized needs. HCBS can be provided in family settings (family foster home, treatment foster home) and may be available in some instances in residential interventions (e.g., for family members and as after-care supports).

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June 2022

DRAFT

Maryland

Family Foster Homes

Treatment Foster Homes

RESIDENTIAL INTERVENTIONS

Residential Intervention: Clinical Class I

Residential Intervention: Clinical Class II (Specialty)

Youth must have a DSM-5 Diagnosis, require clinical intervention that cannot be provided within a family setting due to the intensity of the treatment, and require 24/7 supervision. Youth demonstrates episodes of behavior in home, school and/or community interfering with ability to function in multiple areas due to clinical needs.

Program provides behavioral, clinical, and psychiatric treatment and services, including 3-4 hours of care coordination/week and 8-12 hours/week of clinical treatment interventions & allied health services. Program meets or exceed QRTP Requirements: licensed & accredited; provides trauma-informed care; family participation; 24/7 access to nursing/medical staff. Direct care class of the program will determine the ratio of awake staff.

Clinical Class 2 (Specialty) only: Treatment provided by providers with specialized training, credentials, and/or expertise to support youth related to a current dual diagnosis of a mental health disorder and substance use disorder; current or recent within six months self-injurious behavior; aggressive behaviors and a diagnosis of Autism Spectrum Disorder; a history of sexually inappropriate behaviors; and/or, a history of sexually offending behaviors.

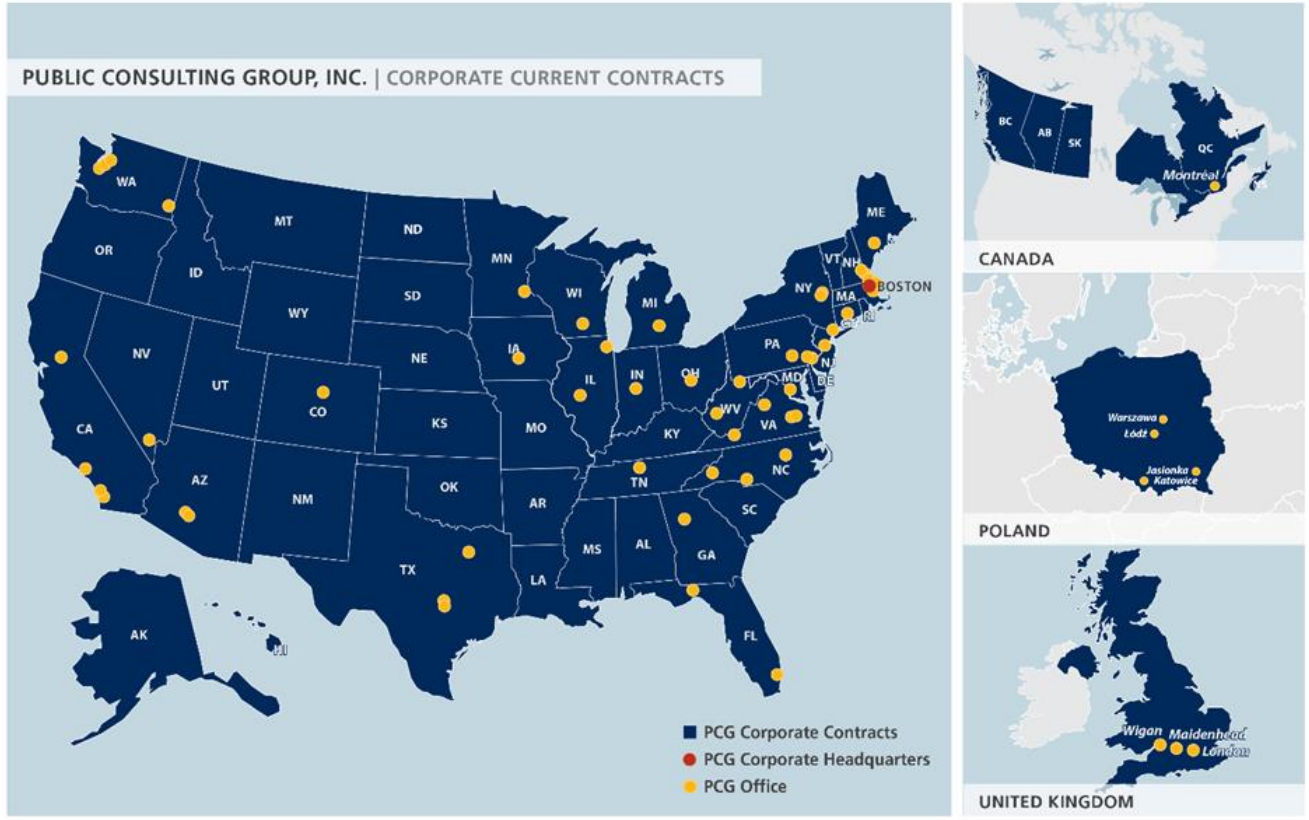
Psychiatric Residential Treatment Facility (PRTF)

Hospital

Home & Community-Based Services

Introducing Public Consulting Group

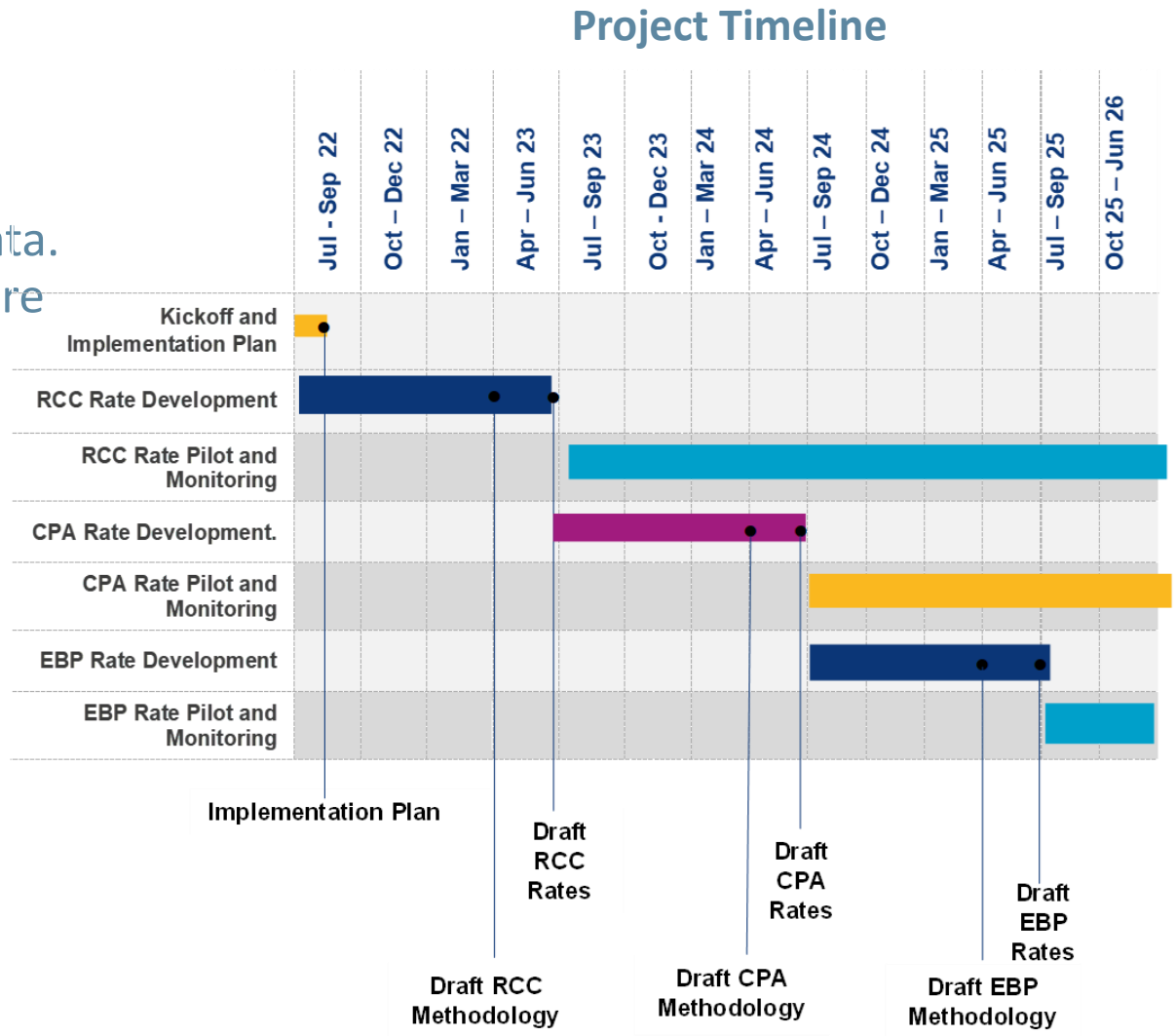
- Jeremy Payne – Project Manager
- Public Consulting Group
  - Founded in 1986, PCG is headquartered in Boston, MA and employs more than 2,500 professionals in 62 offices
  - Public Sector Focus: Management consulting to assist public sector agencies better serve their targeted population, specifically: Human Services | Health | Education | Technology Consulting



Project Overview

Year 1 RCC Rates

- Phase 1 (Jul-Oct 2022)
  - Obtaining program specifications and data.
  - Review service utilization and expenditure data.
  - Document and outline rate models.
- Phase 2 (Nov-Dec 2022)
  - Finalize model ratios.
  - Determine cost elements.
  - Conduct provider meetings.
- Phase 3 (Jan-Jun 2022)
  - Finalize cost elements.
  - Conduct actuarial testing.
  - Finalize rate models.
  - Coordinate model approval.
  - Plan and execute rate monitoring.



Pro Forma Modeling

- A pro forma modeling approach allows decision makers to **use cost data to develop anticipated costs and recommended payment rates** for new or revised comprehensive services when sufficient historical cost data are unavailable. In this case, **the task is to identify the costs associated with the Clinical and Direct Care classes** that will ensure the effective service delivery for the wide array of services needed to serve the youth of Maryland.

- All costs are developed in proportion to each youth per year, which can be divided into a monthly or per diem rate.

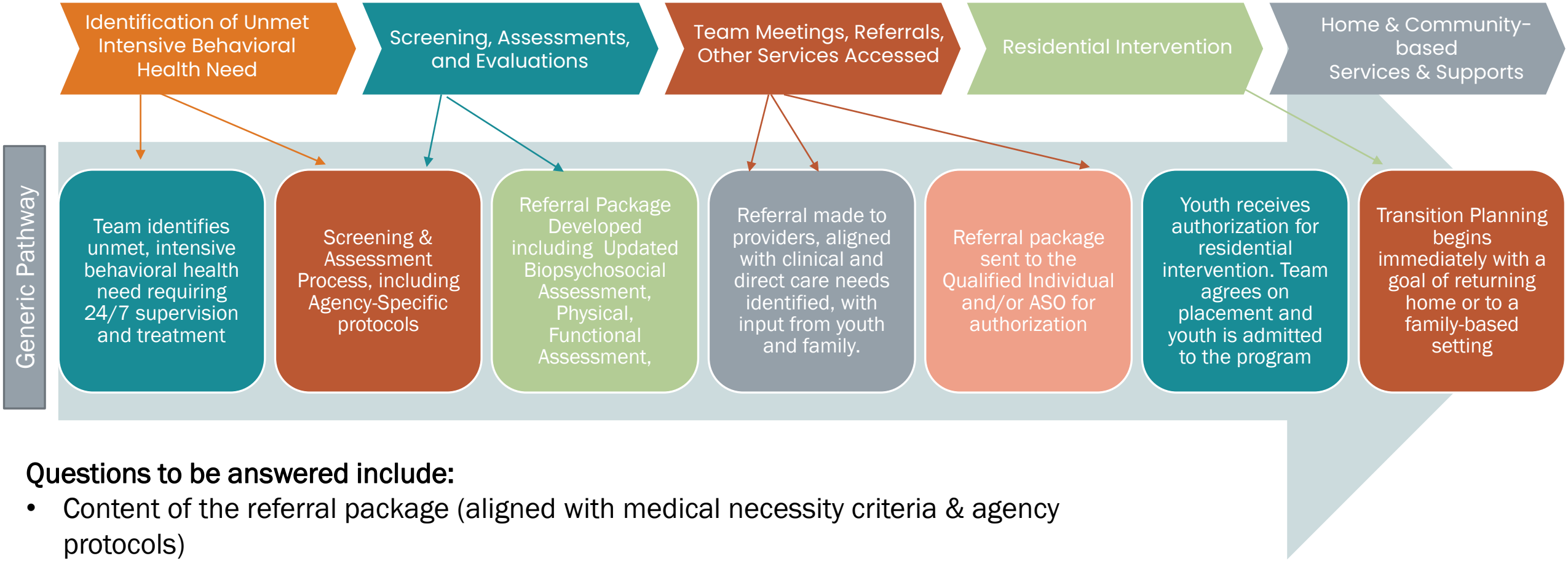
- PCG is planning on using service standards, model budgets (FY23), and national and state benchmarks (BLS, CWLA, other state figures etc.) to ensure accurate cost assumptions, which will be reviewed by stakeholders, including providers.

Getting to Know QRTP Programs

PCG has extracted cost data from Model Budgets for all QRTP providers and will be scheduling meetings with each to learn more about the nuances of each program and understand the positions listed in the model budget to ensure accurate application in the models.

PCG intends to explore other meetings with non-QRTP providers in the coming months as well but will plan those meetings after the first round of QRTP meetings.

Current Activity: Mapping *How* Children and Families Will Access Residential Interventions



Questions to be answered include:

- Content of the referral package (aligned with medical necessity criteria & agency protocols)
- Timing of referrals to providers and submission of referral package to QI, Court, & ASO
- Adjustments to timing and flow for judicial involvement
- Process for transparent and consistent outreach to providers
- Process for obtaining youth and family input into residential intervention selection

Current Opportunities for Stakeholder Engagement

7 provider representatives on the QSRI Subgroup (meets bi-weekly)

- MARFY & Non-MARFY members
- Geographically representative
- Small & large providers
- DHS, DJS, and DDA contracted programs

All QRTP providers invited to serve on the CQI/Performance Measures subgroup

Upcoming and Ongoing PCG outreach and focus groups

QSRI Timeline (as of 11/2022)

- November 2022 (FY23): RCC and CPA providers are updated on the rate revision process but will continue to use the current rate structure and process for billing.
- January-December 2023: Maryland statute and regulations are amended to align with new process
- July 2023: Pilot testing of performance measure collection with QRTPs
- November 2023: Rates for RCC providers are shared for pilot testing. Child Placement Agency rate revision work begins. Full training of RCCs on new rate structure.
- January 2024: Additional statutory and regulatory changes are made, if needed. Rate simulations and projections run to assess impact on RCC providers.
- February 2024: State Plan Amendment submitted to CMS (Pending State Agency agreement), Initial Programming occurs in the Medicaid Management Information System (pending approval by CMS).
- **July 2024: New rates are implemented for residential childcare providers**, with a 1-2 year period of monitoring and ensuring that providers are made whole financially. New performance monitoring begins, with monthly data reporting and quarterly reconciliation.
- January 2025: Rates for CPA providers are shared for pilot testing. Modifications made to Medicaid State Plan, if needed, for CPAs.
- **July 2025: New rates are implemented for child placement agencies**, with a 1-2myear period of monitoring and ensuring that providers are made whole financially. New performance monitoring begins, with monthly data reporting and quarterly reconciliation. Medicaid claiming anticipated.

Simultaneous Work:
-Logic Model & Performance Metric Development
-Medical Necessity Criteria (all Res. Intervention Levels)
-Provider Criteria
-Staffing Qualifications
-Service Description
-Youth enrollment pathways
-Statue & regulation review & updates
-Medicaid State Plan Amendment Development
-Stakeholder Feedback & Engagement Ongoing!

Questions? Suggestions?

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