Core Components of QSRI

Develop and implement a transition plan
Establish performance measures and a CQI process as part of an updated contracting process
Establish consistent rates for clinical and direct care (non-clinical) services
Establish clinical and provider criteria for residential interventions
Establish consistent referral and enrollment pathways
Support provider, agency, and community readiness and workforce development

Submit your feedback here: https://umaryland.az1.qualtrics.com/jfe/form/SV_d6Db6LlBOfJ4mfr
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.

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 and diagnostic setting for children with serious behavioral health needs. Appropriate for children who experience periodic or consistent 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** | 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 diagnostic assessment, and treatment and medical detox when those needs cannot be met in any other setting. |

* 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 equal 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).
Periodic or consistent episodes of behavior in the home or community that are interfering with ability to function in various areas of daily life. 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.

Consistent episodes of behavior in home, school and/or community interfering with ability to function in multiple areas due to clinical needs. Has a 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.

Periodic or consistent episodes of behavior in the home or community that are interfering with ability to function in various areas of daily life. Has DSM-5 diagnosis AND Pregnant/Parenting, Medically Fragile, or demonstrates Sexually Inappropriate Behaviors.

Meet or exceed QRTP Requirements:
- Trauma-informed care; family participation; licensing & accreditation; 24/7 access to nursing/medical staff

May meet QRTP and/or other federal OCS requirements.

Residential Interventions:
- Class 1
- Class 2
- Specialty (may have multiple classes within)

Residential Interventions: Family Foster Homes, Treatment Foster Homes, Psychiatric Residential Treatment Facility (PRTF), Hospital

Home & Community-Based Services

The Institute for Innovation & Implementation, University of Maryland, Baltimore; 2021

QSRI Timeline (as of 11/2021)

- October 2021 (FY22): RFP for rate-setting entity is released
- November 2021 (FY22): IRC continues with current rate process, pending new future rates. Agencies work to support programs becoming QRTPs. Proposals in response to RFP for rate-setting entity are received and reviewed.
- December 2021 (FY22): Oral presentations for rate-setting entity contract
- January 2022 (FY22): Financial Proposals Reviewed
- February 2022 (FY22): Recommendations made for rate-setting entity contract
- March 2022 (FY22): Contract partially executed by selected entity
- March-May 2022 (FY22): Departmental approvals for contract
- June 3, 2022 (FY22): Contract for rate-setting entity goes to the Board of Public Works
- July 1, 2022 (FY23): Contract is established, and RCC rate revision work begins
- November 2022 (FY23): RCC providers begin to receive training on new rate structure and process for billing. CPAs continue to use current IRC rate-setting process.
- January 2023 (FY23): Maryland statute and regulations are amended to align with new process
- January 2024 (FY24): Additional statutory and regulatory changes are made, if needed.
- February 2024 (FY24): Rates for RCC providers are shared for 4-month pilot testing. State Plan Amendment submitted to CMS (Pending State Agency agreement). Initial Programming occurs in the Medicaid Management Information System (pending approval by CMS). Rate simulations and projections run to assess impact on RCC providers.
- July 2024 (FY25): New rates are implemented for residential childcare providers, with a 1-2-year period of monitoring and ensuring that providers are not harmed financially. New performance monitoring begins, with monthly data reporting and quarterly reconciliation.
- February 2025 (FY26): Rates for CPA providers are shared for 4-month pilot testing. Modifications made to Medicaid State Plan, if needed, for CPAs.
- July 2025 (FY26): New rates are implemented for child placement agencies, with a 1-2-year period of monitoring and ensuring that providers are not financially harmed. 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!
Resources

• QSRI Vision Document
• QRTP-PRTF-IMD Comparison Tool
• Maryland QRTP Overview & Designation Process
• CMS Q&A on QRTPs
• Training Institutes Live: Integrating Effective Residential Interventions within Systems of Care
• Training Institutes Live: Transforming Residential Interventions: Data-Informed Practices
• Training Institutes Live: Accrediting Qualified Residential Treatment Programs under the FFPSA: Lessons Learned