

Quality Service Reform Initiative (QSRI) Update

IRC Provider Meeting

November 2021

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Proposed New Rate Methodology

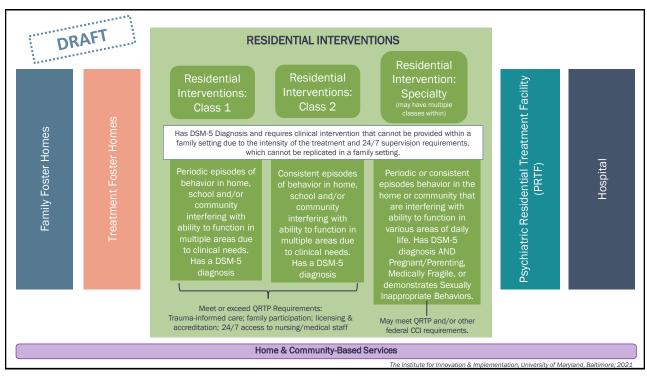
- Uses the framework of the existing IRC process as a foundation for the cost components but it moves AWAY from individual rates based on individual costs
- Establishes direct care rates and clinical care rates
 - Direct Care Rate: A bundled or comprehensive rate to cover operating and other costs related 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.

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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 Hospital (incl. kin, guardianship, pre-adoptive) & Independent Living Programs Residential Setting **Treatment Facility** Structured, 24-hour group care Structured inpatient setting for Inpatient setting for acute treatment and diagnostic setting individuals under age 21 with behavioral health needs for children with serious SED and/or long-term provide behavioral that cannot be met in any behavioral health needs. Appropriate for children who interventions and treatment psychiatric illness who require other setting, even with trinder with a fee thinable in the time 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. ongoing, active treatment that in a stable, family-like individualized experience periodic or consistent episodes of behavior in home, must be provided on an setting. interventions, including inpatient basis under the Developmental and/or when the individual poses school and/or community interfering with ability to function therapeutic treatment needs direction of a physician. The an immediate threat to youth demonstrates clinical exceed what can be self or others. May include in multiple areas due to clinical needs. May specialize to serve evidence of a serious provided in a regular foster short- or long- term stays emotional disorder and home but whose needs can for diagnosis particular populations of youth (e.g. youth who meet these still be met in a home-like exhibits significant assessment, and impairment in functioning, treatment and medical detox when those needs environment. criteria and are pregnant/ parenting, medically fragile, or representing potential serious harm to self or others. cannot be met in any demonstrates sexually inappropriate behaviors). May other setting. include Qualified Residential Treatment Programs (QRTPs) and/or other federal Child Care Institution Requirements. 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 canno 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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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.

 We are here now
- · 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
- · November 2023 (FY24): Child Placement Agency rate revision work begins. Full training of RCCs on new rate structure.
- 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!

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Resources

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

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