Ensuring Sustainability: Maryland’s Development of a 1915(i) State Plan Amendment for Children

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DISCLAIMER

The proposed use of the 1915(i) and the services and rates within it are all subject to change based on fiscal and policy decisions at the State and federal levels, as well as any Supreme Court rulings!
The Context

• The RTC Waiver (1915(c) Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver) is ending on 9/30/12.
• On 10/1/12, there can be no new enrollees in the Waiver in any PRTF Demonstration State without Congressional action; only those youth who are enrolled on or before 9/30/12 will be able to continue to be served.
• When the PRTF Demonstration was established, Congress did authorize (and Maryland is pursuing) a short-term 1915(c) waiver to finish serving the youth who were enrolled as of 9/30/12.
What is the 1915(i) State Plan Amendment (SPA)?

- Statutory authority in section 1915(i) of the Social Security Act
- §1915(i) allows for a State Plan Amendment to provide Home- and Community-Based Services (HCBS) to Elderly and Disabled Individuals for services that the Secretary of HHS can approve under a waiver.
  - Cannot include room and board
  - Must be for individuals whose income does not exceed 150% of the poverty level
  - Must be for individuals for whom, without these services, they would meet the level of care in a hospital, nursing facility, or intermediate care facility for the mentally retarded
- Modified under the ACA to enable States to have more than one 1915(i) SPA, but also requires that it be statewide and with no waiting list.
How does it compare to the 1915(c) Waiver Authority, as operationalized in Maryland for the RTC Waiver?

<table>
<thead>
<tr>
<th><strong>1915(c) PRTF Demonstration Waiver</strong></th>
<th><strong>1915(i) State Plan Amendment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waives requirements under 1915(c) of the Social Security Act, allowing for certain individuals to be served in the community instead of in an institution</td>
<td>Amends Maryland’s Medicaid State Plan and is not a standalone waiver; becomes an entitlement for those who qualify, including meeting clinical criteria and maintaining community Medicaid status</td>
</tr>
<tr>
<td>5-year authorization period</td>
<td>No end date</td>
</tr>
<tr>
<td>Can serve both the community Medicaid eligible children and “family of one” children (those who become eligible in the RTC)</td>
<td>Can only serve community Medicaid eligible children (youth must continue to meet community Medicaid eligibility while enrolled in the 1915(i))</td>
</tr>
<tr>
<td>Must be cost neutral to RTCs</td>
<td>No cost neutrality requirement</td>
</tr>
<tr>
<td>Can limit the number of youth served (slots)</td>
<td>States cannot limit the number of youth served</td>
</tr>
<tr>
<td>Can have a waiting list</td>
<td>No waiting list</td>
</tr>
<tr>
<td>Can limit the parts of the State where the Waiver is available</td>
<td>Has to be available statewide after an initial 5-year phase-in period</td>
</tr>
<tr>
<td>Enrollment requires completion of a Medical Assistance Application, complete Certificate of Need (CON) Documents, and meeting technical eligibility criteria</td>
<td>Enrollment will be streamlined. Only children with a T02 Medicaid coverage group (institutional coverage) will have to complete a new Medicaid application. A new physical will not be required for enrollment if one has been completed within 12 months of enrollment.</td>
</tr>
</tbody>
</table>
Pros & Cons

Pros:
• Able to continue to use the RTC Waiver program model, services, and providers
• Eligible for standard federal financial participation
• Five year waiver with ongoing capacity to renew
• Potential to use this model for multiple populations as a long-term sustainability model for the CMEs, even beyond RTC Waiver participants

Cons/Challenges:
• Cannot limit the number of slots
• Must be statewide, although able to phase-in during initial 5 year waiver period
• Modifications to the structure of the 1915(i) under the Social Security Act were made as part of the ACA—if the law is changed, the 1915(i) structure may change
What other options did we review for feasibility?

- EPSDT
- Psych Rehab Option
- Targeted Case Management
- 1915(b)
- 1915(c)
- 1115 Waiver
- Money Follows the Person
- Health Homes Pilot
How are CMEs funded in Maryland?

• 2009: GOC (on behalf of the Children’s Cabinet) enters into contracts with two organizations to have statewide CME capacity (3 regions)
  – This contract supported the CMEs under the RTC Waiver, both SOC Grants (MD Cares and Rural CARES), and State-only funded populations (juvenile justice and child welfare group home diversion)
  – Contract scheduled to end 6/30/12

• 2012: GOC (on behalf of the Children’s Cabinet) issues an RFP and contracts with one organization (Choices, Inc.) to serve as the single, statewide CME for all of the populations

• Under the 1915(i), DHMH and the Core Service Agencies will designate Targeted Case Management (TCM) providers to serve as the CME for a specified geographic area; these TCM CMEs may or may not be the same as the CME serving the other populations in Maryland
Our Process: June 2011 thru...

1. Review options for Medicaid funding
2. Map out how a child would flow through the process in various theoretical scenarios
3. Identify service gaps in RTC Waiver
   - Issue focused surveys to key stakeholders to identify service gaps in RTC Waiver
   - Review discussions that have occurred over the past two years at the CME Implementation Team (that included the CMEs)
4. Pull together the I-Team: MHA (including MHA’s Medicaid liaison), Core Service Agencies (5, representing different parts of the state), GOC, and University of Maryland (representing RTC Waiver, CHIPRA, SOC Grants, TA Center)
5. Do the research!
   - Cross-walk existing regulations and services
   - Obtain, analyze, and review data
   - Obtain rates, descriptions, and other information from other states (adult and child)
   - Obtain historical documents from Maryland
   - Get technical assistance from CMS
6. Draft service descriptions, provider descriptions, and rates and rest of 1915(i) SPA
7. Update 1915(c) application to ensure consistency and continuity for RTC Waiver participants
8. Create eligibility flowchart and background document to support review of draft 1915(i) SPA
9. Distribute 1915(i) SPA with rates: 1) inside DHMH and then 2) to external stakeholders; make revisions as needed
10. Submit to CMS; respond to questions from CMS; make revisions as needed
11. Draft regulations and begin promulgation process
12. Identify TCM providers who will be CMEs; train in Wraparound Practice Model
13. Draft medical necessity criteria and other policy and quality assurance documents
14. Ensure Wrap-TMS is ready for use by CMEs under 1915(i) SPA; Make modifications to MMIS and other information systems
15. Obtain approval from CMS for 1915(i) SPA
16. Recruit additional providers & provide additional training
17. Start serving youth!
Data

• We have requested more than 12 data sets from The Hilltop Institute at UMBC in the past year, all of which have supported the design of the 1915(i)

• One example of a data request:

### Table 1

<table>
<thead>
<tr>
<th>Age</th>
<th>0-5</th>
<th>6-10</th>
<th>11-13</th>
<th>14-17</th>
<th>18-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY06 (July 1, 2005-June 30, 2006)</td>
<td>77</td>
<td>689</td>
<td>948</td>
<td>1,800</td>
<td>1,069</td>
</tr>
<tr>
<td>FY07 (July 1, 2006-June 30, 2007)</td>
<td>82</td>
<td>729</td>
<td>893</td>
<td>1,723</td>
<td>1,143</td>
</tr>
<tr>
<td>FY08 (July 1, 2007-June 30, 2008)</td>
<td>82</td>
<td>713</td>
<td>892</td>
<td>1,708</td>
<td>1,167</td>
</tr>
<tr>
<td>FY09 (July 1, 2008-June 30, 2009)</td>
<td>51</td>
<td>731</td>
<td>872</td>
<td>1,884</td>
<td>1,299</td>
</tr>
<tr>
<td>FY10 (July 1, 2009-June 30, 2010)</td>
<td>56</td>
<td>810</td>
<td>1,016</td>
<td>2,089</td>
<td>1,460</td>
</tr>
<tr>
<td>FY11 (July 1, 2010-June 30, 2011)</td>
<td>58</td>
<td>910</td>
<td>1,100</td>
<td>2,119</td>
<td>1,441</td>
</tr>
<tr>
<td>TOTALS</td>
<td>406</td>
<td>4,582</td>
<td>5,721</td>
<td>11,323</td>
<td>7,579</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Youth 0-21 with Inpatient Psychiatric Hospitalization (Unduplicated Count)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
</tr>
<tr>
<td>FY06</td>
</tr>
<tr>
<td>FY07</td>
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<tr>
<td>FY08</td>
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<tr>
<td>FY09</td>
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<tr>
<td>FY11</td>
</tr>
<tr>
<td>TOTALS</td>
</tr>
</tbody>
</table>

NOTE: Age to be calculated as age during first inpatient psychiatric hospitalization during the fiscal year.

NOTE: If an inpatient psychiatric hospitalization stay crosses fiscal years, only count it in the year of admission--do not count it in both fiscal years.
1915(i) HCBS Benefit Eligibility Flow Chart

Note: There are additional factors, including MA eligibility, availability of a community placement, etc. that are not reflected here.

Preschool Phil
Youth is 0-5 years old

- ECSII is completed
  - ECSII Score 3 or less
  - ECSII Score 4
  - ECSII Score 5

  Has youth had 2+ psychiatric hospitalizations in the past 12 months?
  - No
  - Yes

  Do the family & Treating Professionals want youth in inpatient hospital (either continued or new admission)?
  - No
  - Yes

  Hospital Diversion

Level of Intensity:
- Public Mental Health System & Community Mental Health Resources, including referral to Targeted Case Management
- Inpatient Hospital

Elementary School Erika
Youth is 6-12 years old

- CASII is completed
  - CASII Score 4 or less
  - CASII Score 5
  - CASII Score 6

  Is youth currently in an RTC?
  - No
  - Yes

  Does youth need to be hospitalized?
  - No
  - Yes

  Has the youth had 2+ psychiatric hospitalizations in the past 12 months or been in an RTC w/in 90 days?
  - No
  - Yes

  Do family and treating professionals want youth to be/remain in an RTC?
  - No
  - Yes

  RTC/Hospital Diversion

Level of Intensity:
- 1915(i) HCBS Benefit Program
  - Can be in community; Not rec. for inpatient

High School Hank
Youth is 13-21 years old

- CASII is completed
  - CASII Score 4 or less
  - CASII Score 5
  - CASII Score 6

  Is youth currently in an RTC?
  - No
  - Yes

  Does youth need to be hospitalized?
  - No
  - Yes

  Has the youth had 3+ psychiatric hospitalizations in the past 12 months or been in an RTC within the past 90 days?
  - No
  - Yes

  Do family and treating professionals want youth to be/remain in an RTC?
  - No
  - Yes

  RTC/Hospital Diversion

Level of Intensity:
- Residential Treatment Center
  - Not rec. for inpatient; unable to be in community

Level of Intensity:
- PMHS & Community Mental Health Resources, including referral to Targeted Case Management
How has the RTC Waiver informed the development of the 1915(i) State Plan Amendment?

• Costs in the RTC Waiver have been consistently lower than expected, helping MHA to understand the package of services families are likely to use and with what frequency.

• Based on feedback from families, CMEs, and providers, an intensive in-home service (IIHS) will be included in the 1915(i) to help support the youth and their family, particularly during the first months after enrollment. This service was missing from the RTC Waiver.

• Based on feedback from the RTC Waiver peer support, respite, and crisis providers modifications have been made to elements of their services and the existing rates of reimbursement.

• There will be a stronger Medicaid-enrolled provider base for the home- and community-based services under the 1915(i) that will support initial implementation.

• Reimbursement has been provided in the State Plan Amendment (SPA) for participation in Child and Family Team meetings, including for public mental health system providers who are part of the youth’s plan of care.
Proposed Services

• Care Coordination (provided by CME who is a TCM Provider)
• Child and Family Team Participation
• Community-Based Respite Care
• Out-of-Home Respite
• Peer-to-Peer Support
• Family and Youth Training
• Mobile Crisis Response and Stabilization
• Intensive In-Home Services
• Expressive & Experiential Behavioral Services (art, dance, drama, music, equine, horticultural)
• Mental Health Consultation to Health Care Professionals
Rates

• Process involved using actual costs for salaries, rent, mileage, etc and projected billable hours
• Need rates to fit within existing fee schedule
• Most are drafted in 15-minute rates, with some daily or weekly rates being proposed
• Issue of balance: Pay a fair and appropriate rate in order to get the quality and type of provider desired but balance with a need to contain costs
How did CHIPRA Support this process?

• Provided staff time to draft services, provider qualifications, and rates

• Provided contracts with The Hilltop Institute and with an economist

• Provided resources through CHCS and GA to access information on service descriptions and rate development in other states
Next Steps

• Regulations will be promulgated based on this document, and will provide additional detail. Medical Necessity Criteria will also be established for each service, and policies and procedures will be written and disseminated as necessary.

• There will be an overall quality assurance process that incorporates SPA, regulations, medical necessity criteria, and other documents.

• The rates will be distributed separately and ultimately may impact the number and type of services provided.

• The SPA must be submitted to CMS and there is a negotiation process between CMS and DHMH before the SPA can be approved.

• Use our SPA as the next iteration of a sustainable model for CMEs; explore ability to turn CMEs into health homes based on lessons learned in implementing the 1915(i) and building on provider and policy foundations from the RTC Waiver and 1915(i).