



UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

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

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A presentation at the CHCS CHIPRA Learning Collaborative

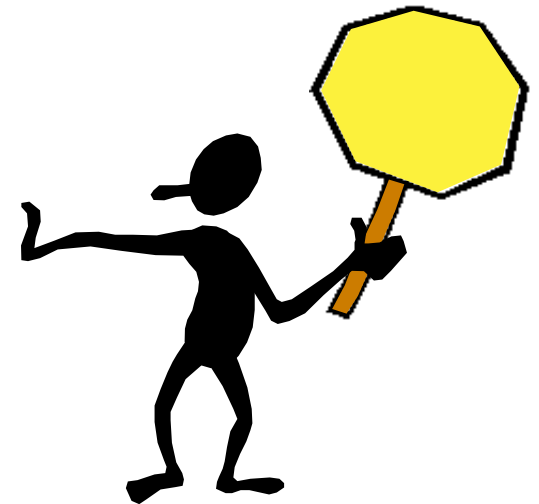
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DISCLAIMER

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?

1915(c) PRTF Demonstration Waiver	1915(i) State Plan Amendment
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	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
5-year authorization period	No end date
Can serve both the community Medicaid eligible children and "family of one" children (those who become eligible in the RTC)	Can only serve community Medicaid eligible children (youth must continue to meet community Medicaid eligibility while enrolled in the 1915(i))
Must be cost neutral to RTCs	No cost neutrality requirement
Can limit the number of youth served (slots)	States cannot limit the number of youth served
Can have a waiting list	No waiting list
Can limit the parts of the State where the Waiver is available	Has to be available statewide after an initial 5-year phase-in period
Enrollment requires completion of a Medical Assistance Application, complete Certificate of Need (CON) Documents, and meeting technical eligibility criteria	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.

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 *We are here*
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:

Analysis of youth (0-21) with inpatient psychiatric hospitalizations, RTC Admissions, and RTC Waiver Enrollment, FY06-FY11 Based on Medicaid claims for youth whose hospitalization, RTC, or RTC Waiver stay was paid by Medicaid (incl MCHP)

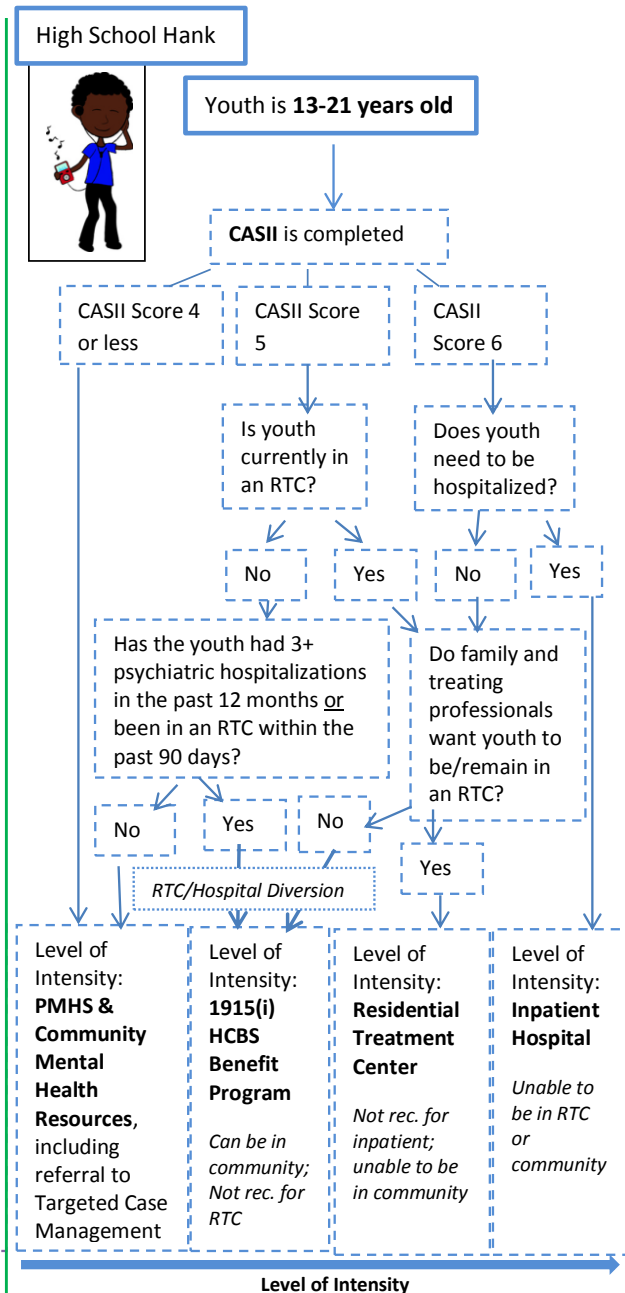
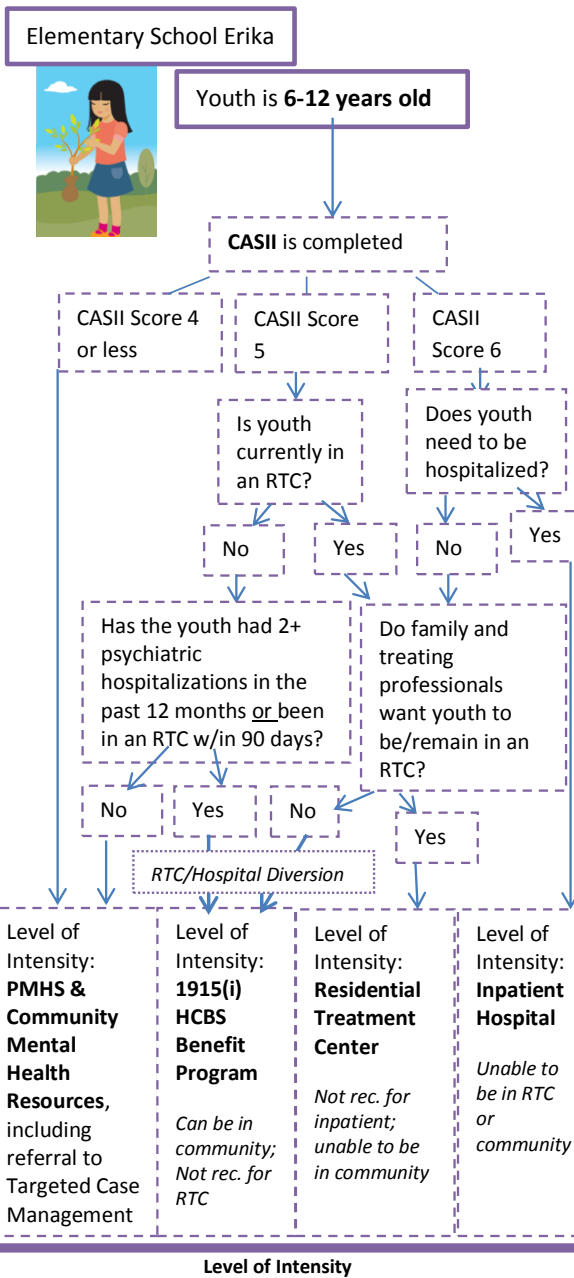
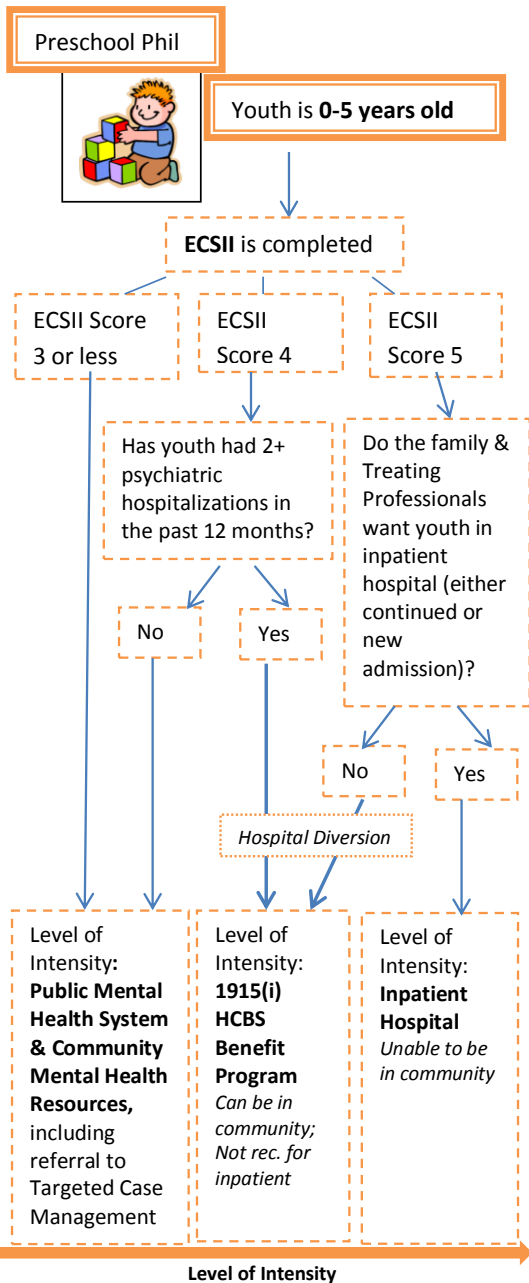
	Number of Inpatient Psychiatric Hospitalizations of Youth 0-21 at Time of Admission (Duplicated Count of Youth)					Number of Youth 0-21 with Inpatient Psychiatric Hospitalization (Unduplicated Count)					
	Age	0-5	6-10	11-13	14-17	18-21	0-5	6-10	11-13	14-17	18-21
FY06 (July 1, 2005-June 30, 2006)		77	689	948	1,800	1,069	58	482	696	1,332	681
FY07 (July 1, 2006-June 30, 2007)		82	729	893	1,723	1,143	53	513	624	1,299	708
FY08 (July 1, 2007-June 30, 2008)		82	713	892	1,708	1,167	61	518	628	1,268	730
FY 09 (July 1, 2008-June 30, 2009)		51	731	872	1,884	1,299	45	532	630	1,404	853
FY 10 (July 1, 2009-June 30, 2010)		56	810	1,016	2,089	1,460	48	566	716	1,546	1,011
FY11 (July 1, 2010-June 30, 2011)		58	910	1,100	2,119	1,441	48	602	763	1,555	1,001
TOTALS		406	4,582	5,721	11,323	7,579	n/a	n/a	n/a	n/a	n/a

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.



How has the RTC Waiver informed the development of the 1915(i) State Plan Amendment?

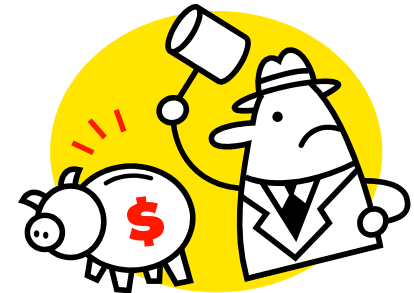
- Costs in the RTC Waiver have been consistently lower than expected, helping MHA to understand the package of services families are likely to use and with what frequency
- Based on feedback from families, CMEs, and providers, an intensive in-home service (IIHS) will be included in the 1915(i) to help 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)

