MARYLAND'S CHILDREN'S QUALITY SERVICE REFORM INITIATIVE

A strategic approach to improving the quality of services for children in residential interventions and increasing the number of children served in family settings

Vision Document

Winter 2021

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Framing the Work

For more than a decade, Maryland has been reducing steadily the number of children in out-of-home placement as well as those placed in residential child care (RCC) programs, commonly referred to as group homes. Despite this, today, *more than 25% of Maryland children in out-of-home placements reside in non-family settings* (Maryland Department of Human Services, 2019). The federal Family First Prevention Services Act (FFPSA, PL 115-123) provides some of the financing tools and opportunities for leverage that are needed to shift to a more prevention-oriented and family-driven approach. However, FFPSA by itself is insufficient because true reform will require the **entire public and private child- and family-serving system to better serve all children in their own homes and communities**.

Almost two-thirds of Maryland's child protective services investigations that result in an indicated or unsubstantiated finding stem from an allegation of neglect (Maryland Department of Human Services, 2019), which is often tied to issues of poverty, inequity, and discrimination.

Among the most persistent structural obstacles to serving children safely and effectively in their own homes or in a family-based setting is an over-utilization of group home placements to meet a child's needs because a family home is unable to be identified, particularly in a timely fashion**.**

> Most chronic equity gaps are linked to larger structural factors that change slowly, if at all, in many high poverty communities: historical oppression and ongoing discrimination; criminalization of populations of color; and income and wealth gaps that are rooted in historical privilege of white people. Yet, knowledge development has *often focused primarily on "down-stream" interventions—those that address individual behaviors and risk factors rather than these persistent structural obstacles.*
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> Marmot, M., 2018, cited in Farrow & Morrison, 2019, p. 10, emphasis added

From Fall 2018 through Spring 2019, interviews, surveys, and large group discussions with State and local public agencies and with private provider organizations identified that, in general, **the child welfare group home placement process is highly variable**. It relies heavily on the individual opinions and expertise of local department of social services (LDSS) staff members across 24 jurisdictions, as well as the availability of placements and the responsiveness of providers. Neither State, local, nor private agencies were able to describe the key characteristics and therapeutic needs of youth who require a non-family setting for the purpose of their own behavioral health treatment needs. Instead, they described youth placed in these settings because it was the most appropriate bed available at the time to meet particular needs (e.g., an older youth with some aggressive behaviors and a history of running away from placements). When asked whether the youth's clinical or behavioral needs could have been met in a family setting, with few exceptions,[1] the answer was "yes," had the necessary home- and community-based services been available.

[1] Most common exceptions noted were youth with significant attachment challenges that had not yet been addressed, youth with significant public safety risk factors and/or impulsive behaviors that were placing themselves or others at risk, and youth with intellectual/developmental disabilities and very impulsive behaviors. All these youth were identified as needing behavioral/treatment plans implemented before safely transitioning into a home setting.

Maryland's vision for a twenty-first century public child- and family-serving system[2] is one that provides necessary services and supports to keep children out of foster care whenever safe and appropriate and ensures the well-being and timely and lasting permanency for those children who do enter foster care.

This vision will be achieved only through practice changes and trauma-responsive care planning and service provision implemented within juvenile services, behavioral health, education, and child welfare agencies, in partnership with families and youth and in collaboration with providers. **Maryland is fortunate to have a community of private RCC agencies who are committed** to the success of each child they serve and who partner with the State to serve children at-risk of out-of-state and more restrictive placements, as well as children with a range of complex needs.

However, even the best group home is not a family home, and research consistently finds that youth have better outcomes when they are in family settings:

- young adults who were discharged or aged out of group care are less successful than their peers in foster care and are more likely to drop out of school;
- group homes deprive children of a normative experience of a stable, home-like environment; and,
- group homes may prevent children from access to peers who can provide positive support (Dozier et al., 2014).

According to the American Orthopsychiatric Association, "group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting" (Dozier et al, 2014, p. 219). The majority of children residing in group homes are ages 13 and older, which poses particular concerns related to supporting healthy and normative adolescent brain development (National Academies of Sciences, Engineering, and Medicine, 2019).

> "For adolescents in the child welfare system, attaining independence gradually while maintaining connections to loving and supportive adults is key to maximizing the opportunities for brain development and resilience, increasing autonomy within a safe nurturing environment."
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> National Academies of Sciences, Engineering, and Medicine, 2019, p. 274

Background

In 2013, the Interagency Rates Committee (IRC) recommended, in response to a request from the Maryland General Assembly's Budget Committees, that the State develop a new rate structure for residential child care programs. The recommendation followed an evaluation that found Maryland's current system for determining rates "doesn't allow for innovation or collaboration; is tied to licensing category instead of services; lacks performance incentives"; disregards location and the challenges of providing care in urban or rural settings; does not allow for the purchase of individual services to meet the child's identified needs; and does not align with the state's budget timeline (Maryland Interagency Rates Committee, 2013).

[2] Throughout this document, child welfare is the primary system of focus because it serves the majority of children in out-of-home placement. However, juvenile services, developmental disabilities, and behavioral health are critical partners in this work. In fact, under FFPSA, Maryland will need to demonstrate that activities undertaken do not result in an increase in the number of children served through juvenile services. Many of the challenges articulated exist for the Department of Juvenile Services (DJS) as well, although it is both a smaller agency and organized differently with placement decisions centralized.

In July 2018, the Maryland Department of Human Services (DHS) contracted with The Institute for Innovation & Implementation (The Institute) at the University of Maryland School of Social Work to provide project management and technical expertise for this work, now known as the Children's Quality Service Reform Initiative (QSRI). DHS also contracted with The Hilltop Institute (Hilltop) at the University of Maryland Baltimore County to provide initial guidance in designing the rate-setting component of the work. The focus of the QSRI is on the segment of the continuum that falls between family-based care (family of origin, kin, guardian, foster, treatment foster, pre-adoptive, or adoptive homes) and a high intensity, restrictive environment that is necessary for the child's and/or community's safety as well as the child's well-being (e.g., residential treatment center/psychiatric residential treatment facility, inpatient hospital, juvenile commitment facility).

The QSRI is a collaborative effort among DHS, DJS, the Department of Health (Behavioral Health, Developmental Disabilities, and Medicaid), the Department of Budget and Management, and the Maryland State Department of Education with The Institute and Hilltop. Private provider organizations and family and youth are critical partners in this work and will be invited to provide insight, comment, review, and recommendations throughout the work, including in response to proposed services, structures, and documents.

The term ***residential intervention*** (RI; see definition in call-out box) is used throughout this initiative to refer to the service that is under review and discussion. It is used instead of RCC, which is a type of license in Maryland. Consistent with current national best practices, *residential intervention* refers to a service or treatment that is *clinical and/or behavioral* and cannot be provided outside of a residential setting. Use of this term reinforces the concept that residential interventions are not simply placements for children but rather a service to meet clinical and/or behavioral health needs.[3]

A residential intervention (RI) is a type of out-of-home placement that provides the necessary treatment services and supports to address a clinical and/or behavioral need of a child that cannot be met outside of the residential setting. It does not include family-based placements (i.e. kinship, guardianship, foster, pre-adoptive, and adoptive homes) and it is less restrictive than residential treatment centers/psychiatric residential treatment facilities, hospitals, or juvenile detention or commitment facilities.

Today, the majority of current RCC providers are unable to bill Medicaid for the clinical components of their services because they do not meet the requirements of specific provider types, such as Outpatient Mental Health Clinics. In order to bill Medicaid under existing outpatient mental health services, individual practitioners within RCC programs would need to enroll as Medicaid providers and bill Medicaid directly if both the child and service met Medicaid requirements. If individual practitioners were required to bill for the clinical components of their services under the current structure, costs would be less predictable and billing would likely need to be reconciled more frequently to ensure providers are being paid adequately. Billing would need to be done by the rendering provider, with the reimbursement signed off to the provider organization (sometimes called

[3] Child Placement Agencies (CPA), which provide private treatment foster care and independent living services, will be the focus of the second phase of QSRI work, including rate reform for those services. The majority of this paper refers to the work being done with RCCs and the development of a residential intervention service provided in a congregate care setting. However, the core components of the QSRI work, described below, will also be applicable with regard to the CPA RI service development. The first focus, however, is on the RCC programs.

the "pay-to-provider") to offset costs while documentation would have to be maintained by both the rendering and pay-to provider.

A new residential intervention service will include comprehensive, consistent service descriptions, medical necessity criteria (MNC; described below), and provider qualifications.

Benefits of establishing a residential intervention service include:

- **Clean alignment with FFPSA.** Maryland can require all providers to go through accreditation, provide trauma-responsive services, have continuous quality improvement (CQI) processes and family engagement plans, etc.

- Costs may be **more predictable** for both the State and providers, with consistent standards and expectations for behavioral health services to be provided within each of the residential interventions (with rates reflecting standards and expectations).

- If Maryland pursues a new or revised service under its Medicaid State Plan, there can be a **streamlining** of the process for providers to enroll as Medicaid providers. Providers who meet qualifications could directly enroll (rather than impose the requirements of an Outpatient Mental Health Clinic or other provider type).

- The State could more easily **track capacity and utilization** under a single provider type with specific expectations for programs within that provider type.

- The State can **better identify programs** that are not providing *clinical* interventions and shift those programs to be home- and community-based service providers, rather than residential providers.

- Maryland can establish **an authorization and independent review process** that would support **CQI activities** as well as possible future Medicaid reimbursement.

Although Maryland is exploring options for creating and/or modifying a service within the Maryland Medicaid State Plan for the residential intervention service, the benefits outlined above are maintained *even if Maryland does not pursue a State Plan Amendment (SPA) for this service and uses State-only or other federal (non-Medicaid) funds.*

The Vision

Maryland believes that children should not have to leave a family setting in order to receive comprehensive clinical and behavioral services and supports. Children can be successful in family settings when they have the right mix and intensity of quality services and when caregivers are supported through strong and consistent communication, responsive services, and the availability of respite care. Maryland's continuum of interventions and services, hereafter called a continuum of care, should promote access to high quality evidence-based and promising practices that help children and families to achieve their goals for themselves, as well as the treatment team's desired outcomes.

The use of the term *continuum* is intentional as it also means that the services and settings are an interconnected system, rather than isolated components; such a system emphasizes prevention,

transition, and discharge planning to bolster the success of children, youth, and families as their identified needs change. The use of the term continuum is not meant to suggest a "fail first" service array but rather a range of services with increasing levels of restrictiveness. A high intensity service can be provided in a home- and community-based setting.

Maryland's vision is one in which:

- All children live in a **committed, permanent home** that preserves, to the fullest extent practicable, the child's familial, peer/social, educational, and cultural ties;

- All children receive services and supports are that are **individualized and trauma-responsive**;

- **Residential interventions are short-term interventions** that meet **clinical and behavioral needs** while offering services and supports to the child's caregiver and siblings, consistent with the child's permanency plan;

- Children access residential interventions through a trauma-responsive process that is **consistent** across the state and across providers, which focuses on leveraging the strengths of the children and their families when providing treatment interventions that are **matched** to their identified needs;

- No child, youth, or family is refused or ejected from services because of the complexity of their history or their current behavioral health needs (**"no eject, no reject"**);

- **CQI** activities support data collection, analysis, and reporting for data-informed decision-making and **shared accountability** to promote safety, permanency, and well-being for children, youth, and families;

- Challenges posed by structural and historical inequities and oppression are recognized and addressed and systems, processes, and services are continually assessed for problems associated with **implicit bias and disproportionate minority contact**, with strategies designed and implemented to address these issues as they arise;

- **Providers are partners** in the important work of supporting children, youth, and families, provide valuable expertise and services, and are compensated equitably and consistently for their work; and,

- **Children, youth, and families are experts** on themselves and their families and their voice and experience are valued and prioritized.

Core Components of the QSRI

The path forward builds upon the considerable work of Place Matters, Alternative Response, Families Blossom, and other initiatives to-date. It will integrate with the work of FFPSA implementation as well as Maryland's Child and Family Services Review (CFSR) findings and the federally funded Center for Excellence in Foster Family Development. The graphic below identifies key areas that must be

attended to by the State Agencies to create the change sought. Each component is discussed in detail in the pages that follow.

Figure 1: Core Components of the QSRI

Core Component: Establish consistent rates for clinical and direct care services

The clinical and/or behavioral health components ("clinical rate") of the residential intervention will be separated from the components of the service that are not considered rehabilitative ("direct care rate"), which is necessary for possible future Medicaid reimbursement. For example, the staff in the residential intervention who provide general supervision and help the children with meals and getting to and from school are an important part of the residential intervention but are not part of the clinical or therapeutic portion of the service. The rate approach for each component is different, as discussed below.

Clinical Care Rate Component

Maryland intends to develop consistent rates based on service specifications and provider qualifications for the clinical and behavioral health services. Medical and dental costs will remain with the Managed Care Organizations and Title IV-E costs will need to be separated clearly from other behavioral health and medical costs. If Maryland pursues Medicaid reimbursement, it will only be able to claim federal Medicaid funds for the clinical components of residential interventions provided in programs that have fewer than 16 beds in total (regardless of whether they meet the QRTP standard) or meet the federal definition of a psychiatric residential treatment facility (Centers for Medicare & Medicaid Services, 2019).

The clinical care rate will be based on the individual, group, and family therapies and related services provided to the child, based on documented need, according to clinical and therapeutic service specifications and provider qualifications. The differences in the clinical care classes will be based on

the duration and frequency of the intervention and the type of practitioner who is offering the therapeutic service or intervention.

The frequency of the services will be included in the service description and the rate calculated based on the frequency of required delivery, likely in daily or weekly increments. The rates for these services will be standardized based on Bureau of Labor Statistics data for personnel costs as well as other standardized data for operating costs. Programs within the same clinical rate class will provide therapeutic services that are of a similar intensity and provided by individuals with similar qualifications (e.g., licensed clinical social worker, licensed professional counselor). Programs providing evidence-based practices (EBPs) will have a higher clinical rate for those services.

Direct Care (Non-Clinical) Rate Component

Maryland intends to utilize a **class rate** for the non-clinical component of the rate. Currently, providers negotiate a rate with the State that is all-inclusive and based on actual and projected costs. The rate awarded is based on those costs, historical costs, and the state's budgetary constraints. In the new approach, Maryland will be able to rebase or revise rates annually or less frequently (e.g., every two or three years), using a cost-of-living adjustment to account for increased costs in years when the rate is not being revised. Providers could request a re-classification or rate change if there is a significant change in their program.

Class rates will have a **base rate** that is inclusive of non-clinical operating costs including food, clothing, transportation, utilities, rent/mortgages, normative childhood activities, and general supervision. The base rate then will be modified for each class to reflect the particular costs associated with maintaining the "therapeutic milieu"[4] as well as personnel costs. Personnel costs will be calculated based on the qualifications of personnel (i.e., years of experience, specific training, and/or credentials), staffing ratios, level of supervision, and work performed.

We estimate that there will be three to five classes for both direct care and clinical rates, although this is a projection. Classes could also be modified to reflect costs of living in different geographic areas of the state, which might impact salaries, utilities, transportation costs, and rent/mortgages. Maryland will want to limit the number of modifiers within each class to avoid rates resembling individual rates. Class rates eliminate negotiation; the State will tell the provider what they want to purchase and how much they will pay for that service. Consistent base rates help the State to require living wages paid to personnel. Class rates offer predictability to providers and the State when planning future costs, and modifiers enable providers to receive rates that cover costs in their geographic area and for their program size. Although calculating the rate components will be a large undertaking, especially when compared with the current rate structure, it should reduce future administrative burden as rates can be rebased by class. This approach will require additional provider input regarding actual costs, as well

[4] The therapeutic milieu is a term that refers to those aspects of the *program* that create a safe, trauma-responsive environment that support normative child development and growth but which are *not* considered clinical, individual therapeutic costs because they are not attached to a specific, clinical rehabilitative need of a particular child. Examples of costs associated with the therapeutic milieu include training and implementation of program-wide service delivery models or approaches, such as Trust-Based Relational Intervention (TBRI) or the Attachment, Regulation and Competency (ARC) Framework, or costs associated with house meetings or social activities. For more information on the concept of the therapeutic milieu, see Leichtman, M. (2006). Residential Treatment of Children and Adolescents: Past, Present, and Future. *American Journal of Orthopsychiatry*, 76, doi:10.1037/0002-9432.76.3.285

as careful reconciliation of costs and holding providers harmless during the first years of implementation.

Louisiana, Massachusetts, New Jersey, and Virginia are all examples of states that use per diem class rates for the non-clinical component of the rate.

The figure below is a hypothetical visualization of individualized rates (current rate structure) versus class rates for residential intervention providers of a similar type.

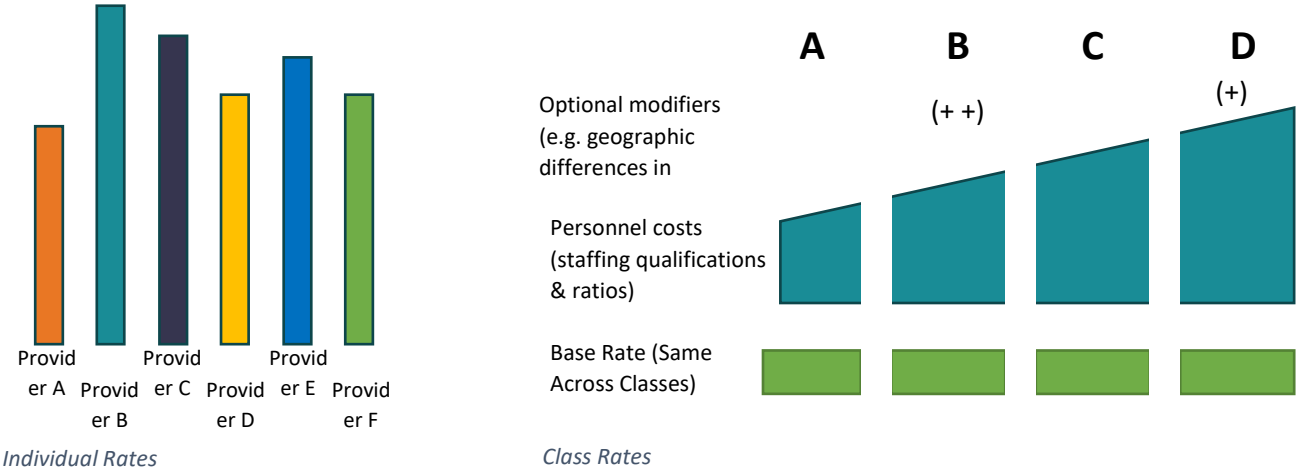

Figure 2 A hypothetical visualization of individualized rates versus class rates for residential intervention providers of a similar type

Core Component: Establish clinical and provider criteria for residential interventions, including for special populations, aligning criteria to qualified residential treatment program (QRTP) quality standards

The new residential intervention service will include the clinical or behavioral treatment for the child being served; **if the child is able to receive the services needed at the necessary intensity *outside* of the residential intervention, the residential intervention should not be needed or authorized.** Therefore, residential intervention providers need to be explicit about the children best served in those settings and the clinical and behavioral treatment interventions provided within the residential intervention.

Currently, Maryland does not have comprehensive, consistent, and aligned service descriptions, provider qualifications, or medical necessity criteria (MNC) for residential interventions or for RCC programs. The existing levels of care and levels of intensity criteria are descriptions of levels of service, some of which overlap with services that should be provided in a family setting; they do not include precise clinical criteria, which is necessary if the service were to be included in Maryland's Medicaid State Plan.

The term "medical necessity criteria" means standards used to determine if the treatment, services, and supports are appropriate and necessary given a child or youth's clinical, social, educational, and other treatment needs; it indicates whether the child or youth's condition meets the required initial and ongoing admission standards. Treatment services and supports are offered at different levels of care.

"Level of care" indicates the intensity of services and supports needed to appropriately, effectively, and safely treat a child or youth in the least restrictive setting.

The residential intervention service description will identify any required treatment models and/or interventions (including any requirement to use evidence-based or promising practices or other specific interventions identified as best practice for particular populations); staffing and supervisory ratios; staff qualifications; and policies related to referrals, acceptance, and denial, as well as any eject/reject policies. The new residential intervention service will have levels of care differentiated by ratios and qualifications of staff. Each level of care will have its own MNC for the clinical care portion of the service.

QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) REQUIREMENTS

- Use a trauma-responsive treatment model to meet the clinical needs of the child
- Facilitate engagement of child's family in treatment, inclusive of siblings (to the extent appropriate and in accordance with the child's best interests)
- Facilitate outreach to the child's family, including siblings, and document how family members are integrated into treatment, including post-discharge, and how sibling connections are maintained
- Provide discharge planning and family-based aftercare support for at least six months post-discharge
- Licensed in accordance with Title IV-E and accredited by an HHS-approved accreditation body
- Have a registered or licensed nursing and other clinical staff on-site according to the treatment model and available 24 hours/day, 7 days/week

Administration for Children & Families (2018)

Within the clinical component of the service, there must be a minimum daily level of treatment to meet the needs of the youth. Each service, and level of intensity or care therein, will specify staffing requirements, ratios and supervisory roles, including supervision by a licensed mental health professional. The staffing requirements will include minimum educational requirements and number of active treatment hours performed by qualified staff per day in the allowed treatment settings and types (e.g., on-site, off-site, individual, group, etc.). Each provider also will be responsible for conducting background checks of their required staff and required substance use testing, as appropriate.

Although some RCC providers offer evidence-based practices in their programs, many do not. Beginning in fall 2018, providers were encouraged to explore evidence-based and promising practices that would be appropriate to offer within their programs to meet the specific needs of the youth they best serve. Examples of such evidence-based interventions include Aggression Replacement Therapy (ART), Dialectical Behavioral Therapy (DBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These interventions would also be of benefit to children in the community to prevent their entry into a residential intervention, but these services would be covered under other billing and contracting mechanisms.

Many of the residential intervention providers will need to meet **new federal Child Care Institution** standards if Maryland is to leverage federal Title IV-E funds for the direct care components of the rate. These standards call out special populations who require particular services and supports when placed outside of a family setting: youth who are prenatal, post-partum, and/or parents; youth ages 18-21; youth who are at-risk of becoming or found to have experienced trafficking; and families who would benefit from residential family-based substance abuse treatment. Additionally, there is a new federally defined program known as a **Qualified Residential Treatment Program** (QRTP) (see sidebar) which has specific requirements for independent assessments of children placed in a QRTP as well as continuing review requirements. QRTPs are not a specific program type as much as they

represent programs that meet a set of quality standards. **Not all residential interventions will be QRTPs (and meet all of the equality standards) but all QRTPs will be residential interventions.**

If the residential intervention (regardless of whether it meets QRTP standards) has been effective, and the practice strategies and tools appropriately utilized and integrated into the transition plan, then the transition back to the home, school, and/or community should be smoother, with no or fewer disruptions. Programs that have reduced their lengths of stay and improved sustained positive outcomes post-residential discharge have shifted from a predominant use of practice strategies and tools focused on supporting the youth to a predominant use of practice strategies and tools focused on supporting the family (Building Bridges Initiative, 2019).

Considerations for Special Populations

Some children and youth involved with foster care and juvenile services require additional service customization. These include youth with diverse sexual orientation and gender identity and expression (SOGIE), or lesbian, gay, bisexual, transgender, queer or questioning, intersex, and Two-Spirit (LGBTQI2S) youth, who are overrepresented in child welfare and juvenile services. A study using data from the nationally representative National Survey of Child and Adolescent Well-Being – II (NSCAW-II) estimated that approximately 22.8% of children in out-of-home care identified as LGBTQ (lesbian, gay, bisexual or questioning), even though they comprise only 7-11% of the population nationally (Martin, Down, & Erney, 2016). Additionally, there are unique needs presented by youth who have experienced trafficking or are at-risk of trafficking, as well as those who are medically fragile, who are pregnant and/or parenting, and who are transitioning to adulthood. These are populations who require customized residential interventions with staff who have the expertise to meet the needs of the youth being served.

See Matarese, M., Greeno, E.J., & Betsinger, A. (2017) *Youth with Diverse Sexual Orientation, Gender Identity and Expression in Child Welfare: A Review of Best Practices* for concrete information for child welfare agencies to ensure programs are appropriately customized to support youth with diverse sexual orientation and gender identity and expression: https://www.qiclgbtq2s.org

Core Component: Establish consistent referral and enrollment pathways

Maryland has numerous referral and enrollment pathways depending on the primary public system the child is involved with, the jurisdiction in which the child resides, and which service is being sought. Children and youth involved with DJS have consistent protocols across jurisdictions and have employed or contracted with social workers and other mental health professionals to conduct psychosocial and other assessments to support decision-making regarding services needed. This approach results in the same clinical and behavioral assessments being administered to every youth. However, children involved with DHS and the LDSS have a more varied experience. The Child and Adolescent Needs and Strengths (CANS) tool is utilized with every youth and family along with other safety and risk assessment tools. However, psychosocial and clinical assessments are completed by many different professionals depending on a variety of factors, including availability. The LDSS worker and supervisor make recommendations for placement with input from the members of the Family Involvement Team; however, final decisions regarding placement in a group home may be based on whether a worker has been able to find a foster home or treatment foster home that will accept the youth.

Maryland must establish consistent protocols and assessment tools for referring and enrolling youth in residential interventions. This approach will support the federal requirements for an independent evaluation under FFPSA for children placed in a QRTP and will be necessary for any future Medicaid authorizations and payment for the clinical component of the rate.

A standardized assessment protocol for children in DHS/LDSS care and custody being referred for residential intervention should include, at a minimum:

- An **independent assessment** of the youth's relevant clinical history, including a standardized health questionnaire and psychological testing;

- Documentation by a **licensed mental health professional** making or supporting a treatment recommendation for a residential intervention, informed by standardized assessments; social, medical, physical, and/or behavioral health histories; case plans; court orders; Individualized Education Program (IEP) plan, 504 plan, and/or school reports; and the input from the youth and family; and,

- Documentation that residential intervention is **not being used as an alternative** to incarceration and/or preventative detention; nor an alternative to a parent, guardian, or agency's capacity to provide a place of residence for the youth; nor as a treatment intervention when less restrictive alternatives are available.

The independent assessment could be conducted by a licensed clinician or team of assessors supervised by a licensed clinician. There are several options for structuring the independent assessment process: (1) a licensed individual or team supervised by a licensed individual could be housed at a State agency; (2) the local departments of social services could house or share a team of assessors; or (3) the assessment process could be contracted out to an administrative services organization or similar entity.

If the clinical component of the service is being reimbursed by Medicaid, the Administrative Service Organization (ASO)[5] will utilize the information from the standardized assessment to authorize payment for the clinical components of the residential intervention. If the clinical component is not being reimbursed through Medicaid, State Agencies will need to determine when and how reviews will be conducted. DHS and DJS will have to develop and implement assurances and protocols for regular documentation review for any providers receiving Medicaid reimbursement. *Such documentation will need to include clinical documentation with the clinical notes of the child served, the date(s) of service, the treating provider, and service(s) provided.*

Regardless of Medicaid reimbursement, **continuing reviews** should be conducted at regular and specified intervals to determine if the youth is making progress toward meeting treatment goals, the plan to transition the youth home or to a family setting, and the projected timeline by which the youth will be transitioned.

Most youth placed in a residential intervention are expected to have a length of stay of less than six months. Any stay greater than six months should be subject to a continuing review every 30

[5] The ASO is contracted by the Maryland Department of Health to manage Medicaid provider enrollment, authorizations for service, continuing reviews, and payments for the public behavioral health system.

days to be completed by an independent assessor with the family, youth, and agency, as well as other professional and natural supports who are part of the youth and family's care planning. **The Director of the LDSS and the Executive Director of the Social Services Administration (SSA) should review residential interventions for children 13 and older that exceed six months.** Residential interventions for children ages 0-8 should be extremely rare. Residential interventions for children 8-12 should be rare and brief with robust written documentation of need and approval by the Director of the LDSS and the Executive Director of SSA.

Emergency admissions into residential interventions should be strictly limited to circumstances documented by a licensed medical or behavioral health professional within 48 hours of admission. Within 72 hours of admission, the residential program must document that the child meets the MNC for admission and that the medically necessary services cannot be provided in a home- or community-based setting. Discharge planning must commence within 72 hours of admission if those criteria are not met.

The State Agencies will need to partner with provider organizations to streamline the referral processes for better consistency and accountability. The following recommendations are intended to support this process:

- All 24 LDSS should use the DHS updated referral packet. All **referral packets must be completed in full**, including the completion of the CANS, except for emergency placements. All DJS workers must follow DJS's referral protocols (see https://djs.maryland.gov/Documents/DRG/DJS-Process-Flowchart_2018.pdf).

- Every provider agency should have a **designated electronic method** for receiving referral packets and 48 business hours in which to review the packet to confirm that the youth aligns with the provider's profile of youth it serves. If so, the provider should place a hold on a bed, if one is available; if there are any concerns about the fit of the youth with the program, those concerns must be raised during that time.

- All **youth should have a chance to visit the provider organization** before a placement is finalized; workers should listen to any concerns the youth raises and address them *before* placing a child in the residential intervention.

- If more than one provider agency accepts the youth for

DHS INTEGRATED PRACTICE MODEL

Core Values: Collaboration, Advocacy, Respect, and Empowerment

Practice Principles: Family-Centered; Culturally and Linguistically-Responsive; Outcomes-Driven; Individualized and Strengths-Based; Safe, Engaged, and Well-Prepared Professional Workforce; Community-Focused; and Trauma-Responsive

Core Practices: Engage, Team, Assess, Plan, Intervene, Monitor and Adapt, and Transition

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DJS GOALS

- Improve positive outcomes for justice-involved youth
- Only use incarceration when necessary for public safety
- Keep committed and detained youth safe while delivering services to meet youth needs
- Ensure a continuum of care for justice-involved youth that is age- and developmentally-appropriate
- Build, value, and retain a diverse, competent, and professional workforce
- Enhance the quality, availability, and use of technology to improve services for staff, youth, and families

placement, the agency should work with the youth and treatment providers to determine which intervention would be best, taking into consideration factors that include supporting meaningful family engagement and participation in treatment and transitions back into home, school, and community.

- The agency must **communicate** within 24 hours to the providers if the youth will not be placed in that program so the provider can release the hold on the bed.

Core Component: Support provider, agency, and community readiness and workforce development, including support for new home- and community-based services

To actualize the vision that all children live in a committed, permanent home, Maryland's child- and family-serving agencies must focus on improving the **availability and accessibility of evidence-based behavioral health interventions** in the community, **services and support for caregivers, foster care recruitment and retention, and reimbursement rates** that support appropriate treatment in the appropriate setting.

Maryland is exploring possibilities for submitting a Medicaid State Plan Amendment (SPA) to include specific home- and community-based services to prevent placement in residential interventions and to support transitions out of residential interventions, including through the Rehabilitation Option, which is done in Massachusetts. Such services could include mobile response and stabilization services (MRSS), peer support, and particular evidence-based and promising practices, such as intensive in-home clinical services, a category of services that could include Multisystemic Therapy (MST) and Functional Family Therapy (FFT). Except under the 1915(i) SPA, Maryland does not explicitly cover evidence-based practices for children under its Public Behavioral Health System. Providers report that they struggle to cover the necessary training and quality oversight with an evidence-based practice under the existing reimbursement rate; historically, in Maryland, in-home evidence-based practices often cost an estimated 20% more than traditional in-home services.

Staff must be equipped with the skills, support, and tools to engage and work successfully with families, implementing a range of practices that correlate to achieving sustained positive outcomes post-residential intervention (Building Bridges Initiative, 2019). DHS and DJS will need to work with local agencies to continue to shift the culture so that safety, permanency, and well-being are more appropriately balanced; this means **supporting workers to think creatively and in partnership with the youth and family to identify services and supports that will enable the youth to remain safely in the home or in a family setting**. This aligns with DHS's Integrated Practice Model and DJS's agency goals (see sidebar above).

DHS and DJS, along with State- and local public child- and family-serving agencies and their community partners, will need to **re-envision what services provided to families and youth should look like and redefine their expectations for effective and quality home- and community-based services.** Reviews from other states and communities have shown that critical components of such systems and continuums of care include:

- Providing **mobile response and stabilization services 24/7**, including within one to two hours of initial placement, with crises defined by the youth and family;

- **Empowering and supporting** caregivers to manage their child's challenges, including with peer support and respite care;

- Assisting caregivers in **navigating** multiple system involvement, such as with juvenile justice and the educational system;

- Emphasizing **natural supports** in the community;

- **Individualizing services** based on person- and family-centered treatment goals;

- Designing system interventions to be **short-term, with regular reviews** of service provision and goal attainment, requiring significant staff training and supervision to continuously monitor quality; and,

- Basing staffing ratios on **intensity** of service delivery.
(Annie E. Casey Foundation, 2015; English, Lieman, Fields, & Schober, 2017; Manley, Schober, Simons, & Zabel, 2018).

If Maryland submits a SPA for specific evidence-based and promising practices, once approved, federal Medicaid will reimburse the State for up to 50% of costs of eligible services provided under the State Plan.[6] Leveraging Medicaid reimbursement will help Maryland to stretch scarce State funds to expand access to services to children and families, ideally to prevent their entry or re-entry into the child welfare or juvenile services systems. Additionally, under FFPSA, Maryland can claim Title IV-E reimbursement costs associated with training the workforce to provide individualized prevention plans, which can include training and coaching on meaningful and authentic family and youth engagement, creating individualized care plans, monitoring outcomes and implementing continuous quality improvement activities, and reviewing plans. FFPSA Title IV-E funds are also available to support some prevention services for families to prevent out-of-home placements, regardless of the family's financial eligibility under Title IV-E. At least 50% of the State's expenditures on these interventions need to be federally approved as interventions with well-supported evidence, but the Title IV-E funds can still support the administrative activities of the care planning work.

Workers must be able to answer *why* a child needs to be placed outside of a family setting if the child is able attend a community school—the services and supports that can be provided in a school setting can also be provided inside of a home, including one-on-one support during challenging transition points during the day, behavioral aides, etc.

[6] Some services, such as respite care, can only be provided with Medicaid funds under particular Medicaid waiver authorities.

Core Component: Establish performance measures and a Continuous Quality Improvement process as part of an updated contracting process

Contracting and oversight practices should be strengthened and include monitoring activities to ensure that residential interventions are consistently safe, high quality, and effective. In particular, contracts with residential providers should emphasize or require the use of effective evidence-based interventions for children in residential settings. Contracts with providers should establish **transition readiness criteria**, including provisions around what constitutes a safe transition. For example, providers may be required to hold beds for a reasonable period of time (seven days or so) when a child is hospitalized, so that the child can return to the program following stabilization. The current residential rates assume that the programs operate with some level of vacancy, such as bed hold days, to offset the costs of these kind of situations. New rates can account for this situation or Maryland can utilize special "hold" rates for these scenarios.

Similarly, federal QRTP requirements include the provision of at least **six months of post-transition services and supports**. This provides an opportunity for providers to offer some of their services in the home and community to support successful transition into a family setting (regardless of type of family—biological, kin/fictive kin, foster, or adoptive) to continue to transfer knowledge and skills to the caregiver(s) in the home. Residential interventions could bill for this service using a post-discharge rate or through other home- and community-based service lines within Medicaid and contracts with State Agencies (for non-clinical services).

As noted above, contracts should specify referral, acceptance, and denial policies to promote transparency and consistency and "no reject, no eject" policies as other states have done. While the notion of "no reject, no eject" policies can be concerning to the provider community, other jurisdictions have successfully enacted these policies. To be successful, the **policy should be implemented in conjunction with the recommendations above**: strengthen the treatment interventions offered at residential interventions and ensure the necessary staffing levels, staff credentials, and staff training for program models. Rates will need to cover the costs of providing these services to the specified population. Additionally, most states with these policies allow for programs to challenge a referral or request an exception to these policies, in writing with supporting documentation, and within certain timeframes; some states actively track and monitor these requests for the purposes of ongoing quality assurance and contract renewal discussions.

Maryland must focus on CQI at both the system and provider levels and engage youth and families to maximize value while improving outcomes for children. Complete, consistent, and specific information about each child is critical to ensuring that Maryland purchases the correct mix of services to prevent residential interventions when appropriate and to transition children home from more restrictive levels of care. **A system that does not measure specific process and outcome measures is a system that cannot fully integrate its practice model and cannot ensure the provision of high-quality services.**

Family engagement principles, including the beliefs that youth belong with their families, families should be respected and engaged, interventions should be in the youth's home and community, and out of home interventions should be as short as possible, must be embedded into the process (Building Bridges, 2017).

Providers will need to be supported and required to collect, report, and use data consistently to improve practice; **the system will need to review, report, and use that data to guide decision-making.** A data dictionary and manual that clearly defines collection terms and periods, and individual

level identifiers such as race, ethnicity, gender, age, etc. will need to be developed. Data collected should be analyzed and reported by age, race, sex, gender, ethnicity, and jurisdiction, as well as any other factors related to disproportionality in care.

As part of the QSRI, Maryland will be developing a theory of change and logic model to identify needed inputs and activities to achieve the desired outcomes of safety, permanency, and well-being. Specific performance metrics will be developed to measure processes, outputs, and outcomes; final measures will be selected based on their specificity, sensitivity, ability to identify meaningful change, ease of collection, and importance (Ringeisen, 2014). Ease of collection is an important consideration, especially for smaller provider organizations.

The data collection, analysis, and reporting protocols that are employed by The Institute on behalf of both DHS and DJS in working with home- and community-based service providers (e.g., Multisystemic Therapy and Functional Family Therapy providers) will be the foundational model for the data collection, analysis, and reporting protocols that will be developed for residential interventions. When performance indicators are selected, they will be presented clearly and transparently; Maryland may want to consider adopting data dashboards for this purpose.

Maryland will utilize **Results-Based Accountability** to align the residential intervention performance measurement with many other measures currently tracked. Measures will explore **quantity** (how much did we do?), **quality** (how well did we do it?), and **effect** (is anyone better off?). Maryland will prioritize measures that have strong communication, data, and proxy power (Clear Impact, 2016).

Maryland will establish **system-level measures** that look across child- and family-serving agencies by jurisdiction or region as well as across the state. These measures could explore access, utilization, and cost, as well as impact on population-level indicators such as entry and re-entry rates. Other measures under consideration will include information at the provider level as well as youth and family outcomes and youth and family experiences of care (Dougherty & Strod, 2014).

Proposed measures will be cross-walked with measures already being collected for existing CQI processes, including for the Child and Family Service Review process, to avoid duplication and to leverage existing data collection and review opportunities. Data collected should be **disaggregated and analyzed by demographic characteristics** to support interventions to address disparities and disproportionality, particularly of children of color in public child- and family-serving systems.

The Administration for Children & Families provides a useful example of the culture shift from merely collecting data to data-informed decision-making:

- *The child scored X.* This is data. Data do not have much meaning without context.
- *The child scored X after receiving case management services.* This is still data. It provides more context but no interpretation of the data's significance.
- *The child scored X before receiving case management services and Y after receiving the services, indicating an improvement in targeted behaviors.* This is information. The original data are combined with other data to determine a value in relation to a reference point.
- *The child is making progress in her socio-emotional and educational development as evidenced by improvement in targeted behaviors, increased school performance, and successful team meetings with family members.* This is knowledge. It combines quantitative and qualitative information from clinical, social, and familial settings. This knowledge allows the child welfare worker to make decisions about scaling services up or down based on evidence from multiple sources over time. If data are collected for multiple children, services can be evaluated and compared at the organization and/or system level.

James Bell & Associates (2018, p. 5), adapted from Anderson, C. (2015). *Creating a data-driven organization.* Sebastopol, CA: O'Reilly.

Examples of measures include:

- Average length of stay
- Re-admissions to 24-hour level of care one year post-transition
- Number of restraints/seclusions divided by the number of youth served, per year
- Number of critical incidents per youth, per year
- Percent of admissions and transitions incorporating comparison of a youth's medication orders during and after the residential episode
- Percent of youth transitioning to a family setting while taking multiple psychotropic medications
- Presence of a child and family team
- Percent of informal supports on child and family team where one is used
- Percent of youth free from child-to-child injuries while enrolled in residential intervention, annually
- Percent of transition type for youth discharged from residential services
- Post-discharge exposure to maltreatment or abuse in the home, in the periods following discharge, as long as follow-up continues but no less than three months

State oversight of each provider type and level of care ultimately will include a review of indicators to assess provider quality. Examples of additional provider-level quality indicators are:

- Excessive calls for law enforcement intervention
- Readmissions within a specified period of time
- Discharge of the child and admission to a higher level of care within a specified level of time
- Staff turnover within a specified period of time
- Number of grievances filed by staff, caregivers, and/or youth

Tying pay to performance is an excellent way to clarify expected outcomes and align the goals of all parties. For example, in Tennessee, payment penalties and bonuses are based on the number of days children are in institutional care, the number of permanent exits from state custody, and the number of children re-entering care. Agencies demonstrating improved performance receive a financial re-investment, which is based on the amount of state dollars "saved" due to their program improvements and the extent to which they have improved their baseline performance relative to savings, permanency, and re-entry. Agencies failing to meet their baseline expectations will be expected to submit a remittance of funds to the state. Tennessee phased in this approach, adding more providers each year, from 2006 through 2009. By 2010, Tennessee had one of the lowest national rates for placing children in congregate care and the initiative was budget neutral (Dougherty & Strod, 2014).

Maryland has an opportunity to lay the foundation for future use of value-based payment. However, the **first several years of rate change will need to include holding providers harmless** for a period of time (one to three years) and **adjusting rates based on reconciliation of data.** The rate methodology must be established and tested. In addition, providers will need time and technical assistance to comply with new requirements, billing protocols, and continuous quality improvement activities with the State. These foundational elements will support successful value-based purchasing in the future.

Core Component: Develop and implement a transition plan to move into new rate and quality structure, including right-sizing the population of children in residential interventions

As noted throughout, many of the recommendations will need to be phased in to support stability for children and for providers. However, it is of critical importance that Maryland does not stop after implementing a transition plan; instead, the focus must be on the design for the future, with stopgap measures implemented to ensure child safety and well-being and provider stability. The transition plan will need to focus on the implementation of the clinical/behavioral health component of the rate and the room and board component of the rate with a process for ensuring that providers do not lose funds during this transition period. During this time, the CQI plan should be implemented and data collected should be used to make adjustments to the rates as appropriate.

Maryland will need to right-size the population of children in residential child care programs so that, when the new rate structure and CQI process is ready for implementation, the number of children in residential interventions more closely mirrors the actual number of children who need this intervention. Maryland will be reviewing all children who have been in a high intensity placement (i.e., outside of a family setting or independent living) for greater than 12 months or who have had three or more high intensity placements in a single year. After an initial review of data, DHS and DJS staff will be working with a team of professionals who will be trained to use a transition tool modeled on New Jersey's transition tool. This tool will assist the team of professionals to collaborate with the youth, family, worker, and treatment provider to identify if the youth is ready to transition to a family setting and, if not, what services need to be put into place to achieve a successful transition. DHS and DJS will review data on youth who have been in a high intensity placement for six to 12 months after completing the first review of youth.

The goal of this process is to serve as an **interruption to a continued placement that may not be in the least restrictive setting** based on the youth's current treatment needs and goals. Coupled with Maryland's new Center for Excellence in Foster Parent Development, Maryland will have a clearer sense of the specific needs of children who require a more intensive service intervention and will be able to recruit, retain, and support foster families and treatment foster families to serve these youth. This will enable the residential intervention providers to specialize in the provision of clinical and behavioral treatment and provide evidence-based and promising practices to support individualized treatment needs of children and youth.

Looking Ahead

QSRI is not a cost-reduction strategy. Maryland's focus is on improving outcomes by breaking the link between placement and services: children will get what they need, when, where, and for how long they need it. Maryland has an opportunity to implement a payment model with a rate structure that is based on a standardized clinical assessment of need while appropriately incentivizing permanency and lower intensity services. As a result, children may require short-term one-on-one supports or aides during a transition to a family-setting or to maintain a child in a family setting. There will be costs to expanding Maryland's home- and community-based service array, including initial and ongoing training and accreditation costs. However, over time, with the necessary services, skilled workforce, full implementation of a CQI process, and appropriate reimbursement structures, fewer children should require more restrictive services, the overall length of stay in out-of-home placement should decrease, and outcomes should improve for children and families.

Input from families, youth, providers, local and state child- and family-serving agencies, researchers, legislators, and other stakeholders is critical to the success of the QSRI. Rapid reform can be disruptive financially and in terms of outcomes for children and families. This work will be successful if the state remains focused on the ultimate outcomes of establishing and sustaining a more accountable, effective, and quality home- and community-based service array and purchasing the services that are needed to help children and families to be successful. A proposed timeline for implementation of the QSRI is found in the Appendix.

As the graphic in the Appendix illustrates, strategically managing complex change is challenging. It requires vision, skills, incentives, resources, and an action plan to achieve change. This document is part of the work to establish the vision for that work, but it will take ongoing, committed, and collective leadership from across Maryland to fulfill the QSRI's promise of change.

> Progress is the nice word we like to use. But change is its motivator….
> The willingness to confront that change will determine how much we shall really do for our youth and how truly meaningful our efforts will be. The test will not be how elaborate we make our proposals for new programs and new funds, but how well these programs affect the inadequacies of old, how willing we are to change the old.
>
> *Attorney General Robert Kennedy, speaking to the U.S. Conference of Mayors, May 25, 1964*

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Appendix 1: Proposed Timeline of Major Activities & Deliverables of QSRI Through March 2023 (FY23) *Activities may extend past FY23, including testing of rates. All dates are tentative and subject to change.*	**Apr-Jun 2020 FY20 Q4**	**Jul-Sep 2020 FY21 Q1**	**Oct-Dec 2020 FY21 Q2**	**Jan-Mar 2021 FY21 Q3**	**Apr-Jun 2021 FY21 Q4**	**Jul-Sep 2021 FY22 Q1**	**Oct-Dec 2021 FY22 Q2**	**Jan-Mar 2022 FY22 Q3**	**Apr-Jun 2022 FY22 Q4**	**Jul-Sep 2022 FY23 Q1**	**Oct-Dec 2022 FY23 Q2**	**Jan-Mar 2023 FY23 Q3**
DHS will establish a contract for the development of rates												
DHS & DJS work on referral and enrollment protocols, aligned with existing policies and requirements and QRTP requirements												
Agencies submit budget requests for FY 22 needs												
DHS & DJS right-size population of youth in RCCs												
Provider qualifications, service descriptions, and medical necessity criteria developed, shared, and refined (first for RCC, then for CPA)												
Draft performance metrics developed and shared for input and feedback (first for RCC then for CPA)												
Legislation and regulations developed to align with new rate process.												
Rate setting entity constructs and tests RCC RI clinical and room/board rates, with input from The Institute and State Agencies and providers. Actuaries test rates.												
IRC process is revised												
Agencies submit budget requests for FY 23 needs												
Rates are tested with RCC providers and adjusted as needed. Data collected.												
If applicable, draft Medicaid SPA for RCC RI is shared for public comment and submitted to CMS. Providers enrolled.												
Rate setting entity constructs and tests CPA RI clinical and room/board rates. Actuaries test rates.												
Agencies submit budget requests for FY24 needs												
CPA RI clinical and room/board rates are tested with performance data.												
If applicable, CPA State Plan Amendment shared for public comment, submitted to CMS. Providers enrolled.												
If applicable, MMIS programmed for CPA RI service.												

Appendix 2: Strategically Managing Complex Change