1915(i): Community Options for Children, Youth, and Families

The following Q&A provides the Department's responses to stakeholder feedback received in response to the draft State Plan Amendment (SPA) released for public comment.

Q: The needs of children age six years and below with serious emotional disturbances (SED) differ from those of their older peers. Would the Department consider addressing the unique characteristics of this population by considering altering the eligibility criteria and services for those less than 6 years?
A: The Department acknowledges the need for services specifically targeting our youngest recipients with SED. While the 1915(i) services will not be stratified by age group and eligibility will remain as currently stated, the Department is in the early stages of considering an additional program for those with serious behavioral health needs ages 0-6. Stakeholders will have an opportunity for input as this initiative develops.

Q: Is there a concern that some of the individuals trained in evidence-based practices (EBP) may be from agencies that do not have the capacity to provide the crisis service component mentioned on page 20 of the SPA in relation to intensive in-home services?
A: This is not relevant to the EBPs currently included in the 1915(i) service array.

Q: Most EBP certification is at the individual, rather than agency level, so while one staff member may have completed certification, others may not have the same level of training. However, the SPA refers to agency certification. This should be reconciled.
A: It is the Department's understanding that with regard to the practices currently included in the 1915(i) service set, it is common practice for all eligible staff members of a provider to obtain the training and/or certification.

Q: We would like to recommend additional training and supervision requirements for in-home stabilizers.
A: In-home stabilizers are currently required to complete "relevant, comprehensive, appropriate training prior to providing services, as…approved by DHMH," In the case of Functional Family Therapy (FFT), for example, this ensures a specified level of supervision and training necessary for service delivery. The Department feels these requirements are adequate at this time.

Q: Providers were advised they were required to be accredited as well as undergo oversight described in the SPA section regarding independent evaluations. Accreditation would give the provider a "deemed status," therefore why all the oversight?
A: The independent assessment requirement is mandated by the federal guidelines, and is therefore not able to be changed. Additionally, the accreditation requirement does not apply to all provider types, and does not include targeted case management (TCM)

providers. The policies are designed so that the role of the Department and the role of accreditation each address different aspects of provider oversight and quality assurance.

Q: Please provide more information about the initial phase in period. Will the program be rolled out by jurisdiction, and if so, will this be determined by need, provider availability, or another factor? What is the time frame for this phase-in period?
A: The Department will determine these operational details on a case-by-case basis as the program is implemented.

Q: Have policies been drafted to oversee the care provided by relatives, legal guardians, etc?
A: The Department has added language to the program policies to specify that immediate family members may not provide 1915(i) services, as is generally stated in similar programs.

Q: The SPA currently lists one element of the eligibility criteria as "the youth is no longer actively engaged in ongoing mental health treatment with a licensed mental health professional." What does this mean? Is there a defined time period?
A: The administrative services organization (ASO) will make a determination based on a review of services and communication with the provider, with a general guideline that if the individual has been disconnected from mental health treatment for 30 days or longer, they will not be eligible.

Q: Will the Department consider allowing recipients to continue to receive the care coordination services of the 1915(i) even after discharge due to psychiatric hospitalization or residential treatment center admission?
A: The Department has removed care coordination from the 1915(i) and placed these within the targeted case management (TCM) program as an additional level of case management, Intensive Care Coordination. Because of this, even if an individual loses eligibility for 1915(i) services, they may still retain eligibility for a lower level of care coordination through the TCM program, thus ensuring continuity of care with their TCM provider. *As a result, effective 7/1/2014, all policies pertaining to care coordination for 1915(i) participants will be found in the TCM regulations.*

Q: Will providers currently participating in the RTC Waiver program be grandfathered in to the 1915(i) program?
A: The Department is developing transition protocols to ensure that qualified and interested RTC Waiver providers may continue to deliver services under the 1915(i) with as little disruption as possible.

Q: Have providers for the additional services been contacted to discuss if the rates provided for in the plan are sufficient? This was a challenge for in home respite with the 1915(c).
A: The Department has welcomed feedback from all potential 1915(i) providers in response to the program, and has received no requests for reconsideration of the proposed

rates. In regard to in-home respite providers, the rate has been doubled since the implementation of the 1915(c).

Q: Are plans of care to be updated annually, monthly, or otherwise? Please clarify.
A: Plans of care for 1915(i) participants are to be updated every 45 days, at minimum. The SPA has been adjusted to reflect this consistently.

Q: There is a need for intensive community and evidence-based treatments in addition to the expansion of care management. Is consideration being given to this?
A: The Department has made an effort to include a range of services and EBPs within the program, and have made note of your comment. The category of intensive in-home services has been purposefully developed to be flexible and allow for a range of treatments.

Q: What was the Department's methodology in calculating the anticipated number of participants to be served? It seems this should be higher than that of the RTC waiver, considering the eligibility criteria.
A: The estimate of 200 participants is based on a service usage analysis. However, this is not a cap, and the enrollment levels could prove to be higher if the need is present.

Q: We recommend that all medically needy MA recipients be automatically financially eligible, using the medically needy coverage option mentioned in CMS materials.
A: The current financial eligibility criteria is a federal limitation; using the medically need coverage option is not possible in this case. CMS materials suggesting otherwise refer only to participants in the 1915(c) program.

Q: How will the program address churn related to financial eligibility criteria?
A: The decision to move care coordination services from the 1915(i) and into the TCM program will allow individuals to continue to receive these services, albeit at a lesser intensity, even if eligibility for the 1915(i) program is lost due to changes in financial status.

Q: We recommend adding a provision that children will be referred to the 1915(i) program without regard to the loss of residential rehabilitation funding.
A: Thank you for the comment; this is not a change the Department is willing to implement at this time.

Q: Would the Department consider extending the participant eligibility criteria of "within 90 days from RTC discharge" to 6 months, and reducing the number of hospitalizations required in year two as the program budget allows?
A: The 90 day requirement will remain. The Department will re-evaluate entry requirements as the program progresses and more information regarding enrollment, need, and resources is available.

Q: Will there be a deadline for eligibility determination by the Department after the submission of a completed application? We recommend 30 days.
A: Crisis applications will be prioritized but timelines for applications are internal policy and not set in regulations or the SPA.

Q: Will there be a timeline or deadline for service authorizations by MHA or its designee?
A: General service authorization requirements currently in place will apply to 1915(i) services.

Q: Youth that are committed, detained, or incarcerated should have care coordination services available to them for a period of time following discharge from the 1915(i) to aid in their transition.
A: Care coordination services are no longer part of the 1915(i) program and will be provided through the TCM program.

Q: How will DHMH determine which practices meet the criteria for IIHS services?
A: Currently, FFT and IHIPPC are approved practices under the IIHS service category. The Department will establish a review protocol for approval of additional practices, utilizing behavioral health staff with clinical expertise in providing services to children and youth. The Behavioral Health Administration will work in partnership with Medicaid to approve additional practices.

Q: We recommend flexibility of limits on IIHS due to the particular EBP time frames and limits that may not coincide with these rules.
A: After consideration of this comment, the Department has removed the majority of service limits from the SPA and will address these as appropriate to each service through other policy mechanisms.

Q: Can you specify the maximum hours or days or respite care and the dollar limit for customizable goods and services that may be billed?
A: This level of detail does not appear in the SPA format; specific limits for each service are being developed and will be included elsewhere.

Q: Mental Health Consultation to Health Care Professionals should be adjusted to include school based and community child care professionals, with the service definition changed accordingly.
A: This may be considered in future service expansions, but not at this time.

Q: The term peer-to-peer support should be changed to family peer support to better reflect the nature of the service.
A: This change has been made.

Q: Family peer support should allow for billing for calls to the care coordinator.
A: This has been addressed in rates development through administrative portion of the rate and will therefore not be an additional billable service.

Q: Please define the customizable goods and services category as participant directed.
A: This change has been made.

Q: Are there concerns that the projected enrollment of 200 may not be high enough to ensure adequate CCO coverage throughout the state?
A: The enrollment estimate of 200 is a projection, rather than a cap and may therefore be higher. Additionally, care coordination activities now fall under TCM, addressing this concern.

Q: Please clarify the rates for EBPs under the IIHS service category.
A: At this time, only the two EBPs listed will be covered. As additional practices are approved, the Department will develop and post their rates as necessary.

Q: We recommend allowing individuals to enroll in the 1915(i) up to age 20.
A: While those enrolled prior to age 18 may remain in the 1915(i) through age 21, they may not enroll after reaching 18 years.

Q: Clinical directors should have completed training if supervising staff carrying out EBPs.
A: Clinical directors must have attended introductory training, but need not obtain certification.

Q: Please add LCPCs to the list of provider qualifications for crisis responders.
A: This has been added.

Q: Please add residential treatment centers (RTC) to the list of providers eligible to provide MCRS services.
A: Residential Treatment Centers will not be eligible to provide MCRS services to 1915(i) recipients at this time. Thank you for the comment.

Q: Care coordinators' plans of care should be supervised by a licensed mental health professional.
A: The clinical director of the CCO will perform a clinical oversight role.

Q: Remove the qualification for family peer support providers stating "or certification by the national Certification Commission for Family Support which certifies individual Certified Parent Support Persons."
A: Thank you for the comment, this qualification will remain as it currently stands.

Q: Please specify in the service requirements for MCRS providers that response must be immediate in the case of a crisis.
A: The SPA has been changed to include this language.

Q: The limits on Mental Health Consultation and Peer Support should be removed to allow for full and appropriate service delivery.
A: As a new program, it is necessary for the Department to see how the services are utilized before opening up limits.