Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

September 12, 2024

The Honorable Pamela Beidle, Chair
Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Joseline A. Peña-Melnyk, Chair
Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

Re: Report required by Health-General Article § 15-1103 and Ch. 378/379 of the Acts of 2023 - 2023 Annual Report on Enrollment in the 1915(i) Model and Child and Adolescent Case Management Services (MSAR #14577)

Dear Chairs Beidle and Peña-Melnyk:

Pursuant to the requirements of Health-General Article § 15-1103 and SB 255/HB 322 (Ch. 378/379 of the Acts of 2023) - *Public Health - Home- and Community-Based Services for Children and Youth*, the Maryland Department of Health (MDH) submits this annual report on enrollment in the 1915(i) model and adolescent case management services.

Thank you for your consideration of this information. If you have questions or need more information about the subjects included in this report, please contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

cc: Marie Grant, JD, Assistant Secretary for Health Policy
Ryan Moran, DrPH, Deputy Secretary, Health Care Financing and Medicaid
Tricia Roddy, Deputy Director, Office of Health Care Financing
Sarah Case-Herron, JD, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

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DEPARTMENT OF HEALTH

2023 Annual Report on Enrollment in the 1915(i) Model and Child and Adolescent Case Management Services

Report required by Health-General Article § 15-1103 and Ch. 378/379 of the Acts of 2023

December 2023

2023 Annual Report on Enrollment in the 1915(i) Model and Child and Adolescent Case Management Services

Pursuant to the requirements of SB 255/HB 322 (Ch. 378/379 of the Acts of 2023) - *Public Health - Home- and Community-Based Services for Children and Youth*, the Maryland Department of Health (MDH) submits this annual report on enrollment in the 1915(i) model and adolescent case management services.

Children's Behavioral Health is a key priority for the Moore-Miller administration, and adequate, accessible, high quality intensive in- home services is a vital component of a successful children's continuum of care. These services are essential to support our high needs youth in the community and to reduce their utilization of the most restrictive institutional settings such as inpatient, residential treatment centers, and other residential congregate care settings.

Availability and utilization of the 1915i services has remained a serious concern for the department since the initiation of the Report on Behavioral Health Services for Children and Young Adults in response to the Maryland Annotated Code, Health-General Article (HG) § 7.5–209. There is recognition that 1915(i) services have continued to be inadequate and highly underutilized. Prior to and throughout FY24, Behavioral Health Administration (BHA) staff have held informal discussions and formal listening sessions with key stakeholders including the Local Behavioral Health Authorities (LBHAs), Targeted Case Management (TCM) provider organizations, family advocacy groups, our Administrative Service Organization, and the 1915i services providers. As a result of this feedback we have identified several areas to target for revision and improvement of the enrollment/reauthorization process, as well as the quality and availability of the clinical elements within this service line. We will continue to collaborate with stakeholders, to include through the Commission on Behavioral Health Care Treatment and Access, the Behavioral Health Advisory Council, and other convening groups, and monitor overall utilization of these services. This will include a deeper evaluation into possible reasons for the further utilization decline in FY23. Additionally the Department will be working in partnership with the other child serving agencies and community-based providers to resolve these challenges and developing a more robust, effective, and easily accessible array of intensive home and community support for all eligible Maryland youth.

Executive Summary

The Maryland Public Behavioral Health System (PBHS) delivers mental health services to over 99,000 children, youth and young adults within a fiscal year with annual expenditures at nearly $500 million for this population. Children's Behavioral Health is a key priority for the Moore-Miller administration, and adequate, accessible, high quality intensive in- home services is a vital component of a successful children's continuum of care.

The total number of children, youth and young adults receiving Targeted Case Management (TCM) and 1915(i) services in the PBHS during fiscal year (FY) 2022 was 2,081 and 36, respectively. One less individual was served in FY 2022 than in 2021 for 1915(i) services, while TCM decreased by 3.3 percent from FY 2021 to FY 2022. TCM services rebounded in FY 2023 with a preliminary increase of 4.8 percent from the prior year, however 1915(i) services in FY 2023 took a significant hit, decreasing by 58 percent over the prior fiscal year. (See Table 1.)

The total associated expenditures for FY 2022 Targeted Case Management and 1915(i) services was $9,971,573 and $133,272, respectively. This represents a 28.5 percent increase for 1915(i) expenditures from the previous fiscal year and a 4.0 percent decrease from the previous time period for TCM services rendered in the PBHS. (See Table 2.)

Together the interaction between high level Targeted Case Management (TCM III) and 1915(i) services, including on demand respite and expanded intensive in home services can serve to fill known gaps in the Children's Behavioral Health Care Continuum. When working as envisioned the partnership of care coordination, the development of child and family driven care plans, and the adequate availability of wrap around support services (under the 1915i waiver) should allow for more effective diversion from higher levels of care and provide adequate community based support allowing for earlier and more stable step down from these higher levels of care.

There is recognition that 1915(i) services have continued to be inadequate and highly underutilized. The Department commits to continue to work closely with all relevant stakeholders to ensure the ongoing progression towards improving access to children's services across the Continuum of Care, including Targeted Case Management and 1915(i) services.

The 1915(i) services have undergone an extensive evaluation process that included assessing eligibility, program administration, person-centered planning, services delivery, within the home and community settings, and reimbursement rates. BHA is in the process of revising and modifying the eligibility criteria by lowering the threshold for assessment, adjusting the requirement for evaluations and the number of emergency department and crisis visits. We are also working to enhance access by establishing a "no wrong door" entry point for services that will allow parents/guardians to self-refer their child and family for services.

Further efforts have been undertaken to gain a deeper understanding of the gaps in child and adolescent behavioral health services. BHA has engaged external experts to assess current services statewide and to develop a roadmap on Maryland's Behavioral Health System focusing on children, adolescents and their families. The assessment and report will be completed by the end of the year, offering a roadmap to guide our efforts in overcoming existing barriers and challenges.

BHA remains committed to addressing workforce challenges that exist in behavioral health by investing in programs that offer training and support to non-mental health professionals. Programs like the Kennedy Krieger Institute ECHO Project and the Maryland Behavioral Health Integration in Pediatric Primary Care enhance the capacity to identify, assess and treat youth from birth to 21 years of age within non-behavioral health settings within the communities where they reside.

Introduction and Overview

The HB 322 report is based upon service utilization data from the PBHS claims data captured through the currently contracted Medicaid Administrative Service Organization (ASO), Optum. The report provides data on the total number of individuals aged 0-22 that have received TCM and/or 1915(i) services within the PBHS by fiscal year and age group.

The data analyzed for three consecutive fiscal years, FY 2021-2023, were pulled for those individuals who received services by service category and associated expenditures. FY 2023 data is available; however, that data is not complete and final as a provider has 12 months from the time of service in which to submit a claim for reimbursement. FY 2023 data will be finalized June 30, 2024; however, based on the current claims data run of October 31, 2023; 90 percent of all claims have been submitted for reimbursement.

1915(i) services are intensive behavioral health services for children, youth and families and builds upon the prior 1915(c) Residential Treatment Center (RTC) waiver that allowed states to provide home- and community-based care to eligible participants with serious emotional disturbances (SED) that otherwise would have been institutionalized. This state plan amendment is intended to support youth with the highest mental health needs as a method to divert a youth from an inpatient or RTC admission or to reduce the length of stay in a facility by providing a number of services not part of the basic Maryland plan to support the youth in the community.

Included in the 1915(i) program are an array of diagnostic and therapeutic mental health services, which are provided to the child or adolescent and family using a wraparound approach that includes intensive care coordination with an individualized plan of care. Specialized services not otherwise available through the Medicaid program include intensive in-home services - currently only one available option, but potentially an array of evidence based treatment models, community-based and infrequently available out-of-home 1915(i) scheduled respite services, family and peer support services, and expressive and experiential behavioral services. The category of expressive and experiential behavioral services is comprised of the alternative mental health treatment modalities: art, dance, equine-assisted, music, drama and horticultural therapies.

The 1915(i) services are available for individuals up to age 18, although services may be extended through to a youth's 22nd birthday if the individual was actively receiving services prior to age 18. 1915(i) qualification has been expanded to individual's with household incomes up to 300 percent of the Federal Poverty Level (FPL) to align with Maryland Children's Health Program (MCHP) eligibility. These services are funded through Medicaid.

Case Management, also known as Targeted Case Management (TCM), are programs available across the lifespan to assist participants with gaining access to the full range of available mental health services, as well as to any needed medical, social, financial, counseling, educational, housing and other supportive services needed to maintain stability in the community. Child and adolescent TCM (also known as care coordination services) providers have three levels of intensity (general, moderate, intensive) to select depending on the needs/presentation of the participant. Intensity level is defined based upon the number of 15-minute units received and billed. *General* level of case management authorizes a maximum of 12 units of TCM per month; *Moderate* level authorizes 13 to 30 units; *Intensive* authorizes 31-60 units of targeted case management services received per month. The eligibility for authorization to a specific level of youth case management is also determined by specific medical necessity criteria designed to provide additional units to cases with higher care coordination needs. These expenditures are funded through Medicaid or through state funds for individuals not eligible for Medicaid but whose financial and medical necessity qualify them for the service.

Data, Trends and Findings

Table 1: Number of Individuals Served in the Maryland Public Behavioral Health System (PBHS) by Service Category and Age Group: FY 2021-23*

1915(i)			
Age Group	**FY 2021**	**FY 2022**	**FY 2023**
0-17	37	36	15
18-22	0	0	1
Total	**37**	**36**	**16**

Targeted Case Management			
Age Group	**FY 2021**	**FY 2022**	**FY 2023**
0-17	1,964	1,893	1,973
18-22	188	188	208

Total	**2,152**	**2,081**	**2,181**

*Data Source: ASO Optum claims paid through October 31, 2023. FY 2023 data are not final as a provider has 12 months from the time of service in which to submit a claim for payment.

The total number of children, youth and young adults receiving TCM and 1915(i) services in the PBHS during FY 2022 was 2,081 and 36, respectively. One less individual was served in FY 2022 than in 2021 for 1915(i) services, while TCM decreased by 3.3 percent from FY 2021 to FY 2022. TCM services rebounded in FY 2023 with a preliminary increase of 4.8 percent from the prior year.

The number of individuals receiving 1915(i) services decreased by 58 percent in FY 2023 from the prior fiscal year. However, this number is expected to increase slightly as the current fiscal year claims data accounts for approximately 90 percent of all claims submitted for reimbursement. FY 2023 is not final as a provider has 12 months from the time of service in which to submit a claim for payment. Final FY 2023 data will be available June 30, 2024.

In FY 2022, .04 percent of all children, youth and young adults served in the PBHS received 1915(i) services, while 2.2 percent of the same population received TCM services. These service utilization percentages remained unchanged from the prior fiscal year.

Table 2: Total Expenditures for Individuals Served in Maryland Public Behavioral Health System (PBHS) by Service Category and Age Group: FY 2021-23*

1915(i)			
Age Group	**FY 2021**	**FY 2022**	**FY 2023**
0-17	$103,756	$133,272	$45,407
18-22	$0	$0	$785
Total	**$103,756**	**$133,272**	**$46,192**

Targeted Case Management			
Age Group	**FY 2021**	**FY 2022**	**FY 2023**
0-17	$9,816,511	$9,537,584	$9,970,868
18-22	$579,592	$433,989	$631,071
Total	**$10,396,103**	**$9,971,573**	**$10,601,939**

*Data Source: ASO Optum claims paid through October 31, 2023. FY 2023 data are not final as a provider has 12 months from the time of service in which to submit a claim for payment.

The total associated expenditures for FY 2022 Targeted Case Management and 1915(i) services was $9,971,573 and $133,272, respectively. This represents a 28.5 percent increase for 1915(i) expenditures from the previous fiscal year and a 4.0 percent decrease from the previous time period for TCM services rendered in the PBHS.

The total expenditures for 1915(i) services decreased by 65 percent in FY 2023 from the prior fiscal year and TCM expenditures increased 6.3 percent from FY 2022. These totals are expected to increase slightly as the current fiscal year claims data accounts for approximately 90 percent of all claims submitted for reimbursement. FY 2023 is not final as a provider has 12 months from the time of service in which to submit a claim for payment. Final FY 2023 data will be available June 30, 2024.

Next Steps

MDH has asked the Local Behavioral Health Authorities (LBHAs)/Core Service Agencies (CSAs) to increase community outreach efforts to address the underutilization of these programs. MDH has requested each jurisdiction to consider selecting more than one provider upon their next five-year procurement cycle, allowing for additional provider choice and more flexibility for families located near the borders of other counties. Additionally, MDH has been working with the ASO to identify potential 1915(i) providers to increase provider capacity.

MDH has initiated additional listening sessions with other stakeholders to begin to discuss strengths and challenges of these programs. These sessions include representation from community advocates to include Mental Health Association of Maryland (MHAMD), Maryland Coalition of Families (MCF) and Community Behavioral Health (CBH); sister agencies to include Department of Human Services (DHS) and Department of Juvenile Services (DJS); community partners to include LBHAs/CSAs, University of Maryland at Baltimore and Local Care Teams (LCTs); along with Care Coordination Organization CCOs, the ASO and the Medicaid policy staff. These listening sessions also helped shape MDH's ongoing discussion about exploring options to expand the available evidence based in home interventions within the intensive in home services subcategory of 1915(i) services.

Early Childhood Recommendations

In response to HB 322/SB 255, MDH surveyed and held listening sessions both with general stakeholders (including representation from providers, policy advocates, parent advocates and Medicaid policy staff) and in accordance with the legislative request, one targeting the early childhood community. The early childhood community members had several recommendations that were aimed at building out a service array for very young children that would be easy to

access in four key settings (*i.e.*, in homes, in pediatric offices, in childcare settings and in schools). Going forward, MDH hopes to identify appropriate evidence-based practices (EBPs) specific to ages zero to five that can be incorporated into the 1915(i) service array. MDH will continue to have ongoing conversations to address gaps and opportunities in the early childhood mental health continuum of care.

Conclusion

This report is intended as a preliminary document to provide the requested information to the Maryland General Assembly, regarding the TCM III and 1915(i) service utilization data and the early childhood stakeholders input, but also to serve as the first update of an ongoing effort to revitalize this program and re-establish these services as an effective element in the Children's Behavioral Health Services Continuum.