

**Maryland General Assembly
Department of Legislative Services**

**Proposed Regulations
Department of Health and Mental Hygiene
(DLS Control No. 14-142)**

Overview and Legal and Fiscal Impact

The regulations implement a home and community-based services benefit for children and youth with serious emotional disturbances and their families, authorized under a 1915(i) Medicaid State Plan Amendment.

The regulations present no legal issue of concern.

There is no fiscal impact on State or local agencies.

Regulations of COMAR Affected

Department of Health and Mental Hygiene:

Medical Care Programs: 1915(i) Community Options for Children, Youth, and Families:
COMAR 10.09.89.01-.20

Legal Analysis

Background

Over the past several years, Maryland has operated a special Centers for Medicare and Medicaid Services (CMS) demonstration project known locally as the Residential Treatment Center (RTC) Waiver. This time limited demonstration project used a special authority granted by the federal government under Section 1915(c) of the Social Security Act to provide home and community-based services for children and youth with emotional disturbances and their families. The demonstration project has now effectively reached its statutory end.

In order to sustain and refine the approach undertaken in the initial CMS Demonstration Project, the State is obtaining a 1915(i) State Plan Amendment (SPA) to serve a similar, but not identical, population of youth and families as prescribed by the federal government. According to the Department of Health and Mental Hygiene, the service mix proposed is also similar to the initial demonstration, but has been refined and enriched, based on lessons learned from the process of implementing the original project.

In addition to the full range of Medicaid somatic and behavioral health benefits available to all eligible individuals, participants enrolled in the proposed 1915(i) SPA will have access to a number of additional specialized services if they meet applicable medical necessity criteria.

Summary of Regulations

The regulations implement a home and community-based services benefit for children and youth with serious emotional disturbances and their families, authorized under a 1915(i) Medicaid State Plan Amendment. As described in the scope of the regulations, eligible participants are served by care coordination organizations through a wraparound service delivery model that utilizes child and family teams to create and implement individualized plans of care that are driven by the strength and needs of the participants and their families.

In addition to establishing the scope of the regulations, the regulations define terms used in the regulations and establish, among other things, parameters for participant eligibility, circumstances prompting termination of enrollment from the 1915(i) Community Options for Children, Youth, and Families Program (1915(i) program), requirements for the 1915(i) program model of service delivery, conditions for provider participation, procedures for program application denials and disciplinary actions taken against providers, services covered, limitations on reimbursement, and payment procedures.

Definitions

Among other terms, the regulations define “care coordination organization (CCO)” as an entity with a minimum of three years experience providing care coordination services that is approved by the department to provide case management services to 1915(i) program participants and their families. A “child and family team” is defined to mean a team of individuals selected by the participant and family to work with them to design and implement a plan of care. The regulations define a “plan of care” to mean a written document that is developed by the child and family team that describes the services to be provided to the participant and that is approved by the department.

Participant Eligibility

To be eligible for 1915(i) program services, an applicant must be younger than 18 years old at the time of enrollment, reside in a home-and community-based setting that is located in a 1915(i) service area and not in an area excluded from the 1915(i) program (*e.g.*, Therapeutic Group Home), and meet other Medicaid eligibility criteria. An applicant must also, among other requirements, have a face-to-face psychiatric evaluation that assigns a Diagnostic and Statistical Manual behavioral health diagnosis, determines the applicant to be amenable to treatment, and is conducted by a provider not associated with the CCO by which the participant may eventually be served. An applicant must also meet the department’s written medical necessity criteria, and the accessibility or intensity of currently available community supports or services must be inadequate to meet the applicant’s needs due to the severity of the impairment without the provision of one or more of the services contained in the 1915(i) benefit.

If the applicant is determined to meet the needs-based eligibility criteria, the department must obtain written consent from the family or medical guardian and ensure that the participant is referred immediately upon enrollment to a CCO. The department must reevaluate a participant’s eligibility for 1915(i) program services every 12 months or more frequently due to a significant change in the participant’s condition or needs.

Termination of Participant Enrollment

Under the regulations, a participant must be disenrolled from the 1915(i) program if the participant no longer meets all of the specified eligibility criteria. Other grounds for required termination of enrollment include hospitalization of a participant for longer than 30 days, a participant's turning 22 years old, the detention or commitment of a participant to a juvenile justice or correctional facility or incarceration for longer than 60 days, a participant's failure to participate in a child and family team meeting within 90 days, or a participant no longer being actively engaged in ongoing behavioral health treatment with a licensed mental health professional.

1915(i) Model

The regulations specify that the 1915(i) model must provide community-based treatment to children with serious emotional disturbance through a wraparound service delivery process. Enrollment in the 1915(i) program qualifies and requires the participant to receive case management services through a CCO. Each participant must have a plan of care that is managed by the CCO. In partnership with the CCO, the child and family team must, among other required actions, reevaluate the plan of care at least every 45 days, determine the needs that the team will work on, identify the individuals responsible for each of the strategies in the plan of care, and meet at least every 45 days, or more frequently as clinically indicated, to coordinate the implementation of the plan of care and reevaluate and update the plan as necessary. Participants must have access to specialty behavioral health services through the department's public behavioral health system and be enrolled in HealthChoice, Medicaid's managed care program, in accordance with eligibility requirements specified in regulations.

Conditions for Provider Participation

To provide 1915(i) program services, a provider applicant must, among other requirements, attest that the provider applicant is in compliance with the general provider requirements and specific 1915(i) service requirements set forth in specified regulations. A provider that proposes to change its 1915(i) service sites by adding, closing, or moving locations must submit an application modification to the department. The department may grant approval to an applicant provider if the department determines that the provider has no deficiencies that constitute a threat to the health, safety, or welfare of the individuals served and attests that the applicant provider complies with the requirements set forth in the regulations.

Providers of 1915(i) program services must also meet specified general conditions for participation. Among other requirements, a provider must have a provider agreement that includes adherence to quality assurance, auditing, and monitoring policies and procedures; receive training and certification as required and approved by the department and determined to be appropriate for the level of care and scope of services provided; maintain general liability insurance; and maintain administrative and medical records meeting certain standards. In addition, the regulations require providers to perform criminal history record checks for all staff, volunteers, students, and any individual providing services to participants and their families in the 1915(i) program. Providers must also, for each individual providing services to participants and their families, perform a background check for abuse and neglect.

To provide services, a provider may not be a participant's family member, have a certain criminal history, or be determined to have engaged in abuse, misappropriation of property,

financial exploitation, or neglect by any professional licensing or certification boards or on any other registry. The department may waive provisions prohibiting employment under specified circumstances, such as having a criminal history that does not indicate behavior that is potentially harmful to the participant or participant's family.

Denial, Emergency Suspension of Approval, and Disciplinary Action

Under the regulations, the department must give written notice of a proposal to deny approval that contains specified information to the provider applicant, the CCO, and the administrative services organization. Regarding disciplinary action, the regulations authorize the department to revoke or suspend an approval, impose probation with conditions, or ban new admissions. The department may propose to take one of these actions if the provider is out of compliance with the requirements of the regulations, fails to maintain financial viability, or obtains or attempts to obtain approval or payment by fraud, misrepresentation, or the submission of false information. The department also may order the immediate suspension of the approval of a provider and the cessation of operation upon findings of conditions that pose an imminent risk to the health, safety, or welfare of an individual served by a provider. The regulations specify notice and other due process procedures for proposed disciplinary actions, including emergency suspensions.

Covered Services and Reimbursement

The regulations establish the services covered, detail requirements that must be met for coverage, and specify required reimbursement for services under the 1915(i) program. More specifically, the regulations include provisions governing coverage and reimbursement of customized goods and services, family peer support services, respite services, expressive and behavioral services, mobile crisis response services, and intensive in-home services.

Limitations on Reimbursement

Reimbursement must be made by the 1915(i) program only when certain requirements are met. The regulations specify certain services that may not be reimbursed under the program, such as services that are not medically necessary, not appropriately documented, or part of another service paid for by the State. Regulations also establish quantitative, durational, and other limits on certain reimbursable services, such as limiting reimbursement for community-based respite to six hours per day.

Payment Procedures and Other Regulations

The regulations specify procedures service providers must follow to receive payment and establish how payments are to be made for services rendered. The regulations also establish, by cross-reference to other existing regulations, procedures for the reimbursement of providers and overpayments by the department; grounds and procedures for the suspension or removal of providers and the imposition of sanctions; and appeal procedures for providers, applicants, and participants.

Legal Issue

The regulations present no legal issue of concern.

Statutory Authority and Legislative Intent

The department cites § 2-104(b) of the Health – General Article as authority for the regulations. Section 2-104(b) authorizes the Secretary of Health and Mental Hygiene to adopt regulations to carry out provisions of law that are within the jurisdiction of the Secretary. Although not cited by the department, § 15-103 of the Health – General Article gives the Secretary broad authority to regulate Medicaid.

With the addition of § 15-103, the authority cited by the department is correct and complete. The regulations comply with the legislative intent of the law.

Fiscal Analysis

There is no fiscal impact on State or local agencies.

Agency Estimate of Projected Fiscal Impact

The regulations implement a home- and community-based services program for children and youth with serious emotional disturbances and their families, as authorized under a § 1915(i) Medicaid State Plan Amendment. The department advises that the program, which replaces the current § 1915(c) program, will allow recipients already eligible for institutional care to instead receive community-based services and avoid the cost of residential treatment. The program is intended to be cost-neutral; thus, there is no significant economic impact. The Department of Legislative Services concurs.

Impact on Budget

There is no impact on the State operating or capital budget.

Agency Estimate of Projected Small Business Impact

The department advises that the regulations have minimal or no economic impact on small businesses in the State. The Department of Legislative Services concurs.

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