COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

March 27, 2024

Alyssa Lord
Deputy Secretary for Behavioral Health
Behavioral Health Administration
Maryland Department of Health
201 West Preston Street, Room 512
Baltimore, MD 21201

Re: Public Notice for Renewal and Changes to the 1915(i) State Plan

Dear Ms. Lord,

Please accept this letter as the formal comments from the Community Behavioral Health Association of Maryland (CBH) on proposed State Plan Amendment (SPA) changes for Maryland's 1915(i) State Plan.

CBH is the leading voice for community-based providers serving the mental health and addiction-related needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system. According to provider directories received in 2021, CBH represents Care Coordination Organizations (CCOs) in 15 of Maryland's 24 jurisdictions, 75% of intensive in-home services (IIHS) providers, and two-thirds of respite care providers. CBH also represents a number of organizations who have dropped out of 1915(i) participation over the last eight years.

CBH thanks the Department for its efforts to strengthen the continuum of care for children needing intensive mental health interventions. Providers of services funded under the 1915(i) state plan receive too few referrals to sustain a business model. Administrative barriers create hurdles to entering the program and maintaining a sufficient workforce, while the clinical admission criteria are too restrictive and the rate too low. Each aspect of these barriers needs to be addressed in order to create a more robust 1915(i) program with the capacity needed to support children with a high acuity of mental health need.

To that end, CBH offers the following recommendations for the Maryland Department of Health's consideration for changes to the proposed 1915(i) State Plan Amendment:

1. **Amend the 1915(i) rate methodology and reimbursement.**

The proposed changes to the 1915(i) SPA do not impact current reimbursement rate or rate methodologies. The current methodology is not consistent with the Medicaid reimbursement rate for therapy in OMHC settings, or with non-Medicaid EBP therapies funded by state funds. Moreover, the rate methodology described in the State Plan is not sufficient to sustain the service, resulting in a significant shortfall of provider capacity.

For these reasons, CBH recommends that rate methodology be amended to reflect that it should be adequate to achieve needed treatment capacity, rationally related to provider cost, and annually updated to keep pace with inflation. See comments below on rates for specific components of 1915(i) program.

2. **Develop conflict of interest workarounds in rural areas.**

The state plan requires that the persons performing evaluations, assessments, and care plans are not also providers of 1915(i) services (page 5). Separation of care planning from care delivery can result in poorly coordinated care. CBH recommends that MDH exercise its option under the state plan to seek workarounds to the conflict-of-interest prohibitions, especially in rural areas of state.

3. **Eliminate separate financial eligibility processes.**

It is our understanding that there is little functional difference between the current 1915(i) financial eligibility and Medicaid eligibility, yet the current SPA requires a separate financial eligibility verification process. It is unclear whether the proposed state plan's financial eligibility election will solve this problem (page 6). Having a separate financial eligibility verification step creates delays and barriers to accessing care. CBH recommends removing this step by allowing any child with active Medicaid eligibility to be automatically deemed financially eligible for 1915(i) without a separate eligibility verification process.

4. **Modify clinical eligibility to increase access by needed populations.**

The 1915(i) plan anticipates serving 200 children annually (page 6). This is simply too few children to sustain statewide provider capacity in the range of covered services. There were 5,966 children with a Medicaid-paid inpatient psychiatric stay in 2021, and 12,613 with a Medicaid-paid Emergency Department visit in 2019.

Expansion of clinical eligibility will allow the 1915(i) services to better function to divert and stepdown children from higher levels of care (pages 9-11), while also creating the volume needed to sustain state-wide service capacity. To that end, CBH offers the following suggested modifications to clinical eligibility standards for the 1915(i) program:

a. **Eligible if stepping down from single episode of higher level of care**. Change clinical eligibility to allow child to qualify for 1915(i) after discharge from a *single* psychiatric inpatient episode, not two or more, and to qualify after discharge from *single* episode of residential treatment center (RTC) setting.

b. **Waive CASII evaluation if child being discharged from higher level of care**. CBH recommends waiving the CASII evaluation if a children is stepping down to 1915(i) from an RTC or inpatient hospital setting. Completion of CASII in these circumstances is medically unnecessary and creates barriers or delays accessing care at time when warm hand-off concurrent with discharge is valuable.

c. **Change clinical eligibility to CASII score *OR* crisis/hospital utilization, not both**. Requiring the CASII evaluation score *plus* a history of crisis/hospital utilization is overly restrictive and will reduce access to 1915(i) from children who would benefit from it. CBH recommends using the CASII evaluation to determine eligibility if a child does not have a history of hospital utilization, but that children with a history of hospital utilization should be independently eligible for the program. If a child has a high CASII score but no hospital utilization, the 1915(i) program can divert a family from future hospital utilization. Similarly, a child with a low CASII score but high history of hospital utilization may benefit from a service to connect the family to appropriate levels of care.

d. **Change clinical eligibility to encompass risk of out-of-home placement across as child welfare or juvenile justice settings**. CBH recommends that the Medicaid benefit package for children be modified to include an array of evidence-based services designed to meet the needs of children at risk of out-of-home placement, including those in child welfare or juvenile justice settings. For these reasons, CBH suggests that the SPA be amended to ensure that clinical eligibility for IIHS and the covered EBPs are aligned with needs of child welfare (DBT, TF-CBT) and juvenile justice (MST, FFT) settings.

5. Make the CCO directory publicly available.

The proposed state plan indicates that a directory of CCOs shall be made available to families (page 16). The directory should be publicly available via a public-facing statewide website or available promptly upon request from the public to the Behavioral Health Administration.

6. Strengthen the IIHS model.

a. **Allow care delivery by lower levels of licensure consistent with EBP model**. The proposed SPA indicates that IIHS must be delivered licensed certified social worker (LCSW), LCSW-C, LCPC, psychologist, psychiatrist, nurse psychotherapist, or APRN/PMH (page 23). By contrast, many EBPs allow therapy to be delivered by a lower level of licensure while under supervision. For example, LMSWs are eligible to become certified therapists of functional family therapy (FFT),[1] multisystemic therapy (MST),[2] or trauma-focused cognitive behavior therapy (TF-CBT).[3] We

[1] Functional Family Therapy LLC, "Sample Job Description."
[2] MST Resources, "MST Therapist Jobs."
[3] TFCBT, "Certification Criteria."

recommend that the proposed SPA be modified to allow LMSWs to function as therapists.

b. **Transparency**. The IIHS provider directory should be publicly available via a public-facing statewide website or available promptly upon request from the public to the Behavioral Health Administration (page 22).

c. **Clarify licensure limits**. The SPA indicates that IIHS license is limited to residential mental health settings in COMAR 10.63.04 (page 22). It is unclear how this provider category aligns with the delivery model. Intensive in-home services should be available to children in the least restrictive setting.

d. **Create consistent and adequate rates**. The proposed SPA states, **"**The rate is higher for those programs that are identified as an EBP, in keeping with the established practice of different reimbursement rates for an EBP versus non-EBP service (e.g., Mobile Treatment Services and Assertive Community Treatment)" (page 56). The differential between the EBP and non-EBP rate for IIHS is 26%. By contrast, an ACT provider is paid 41% more than their non-EBP equivalent.[4] The District of Columbia, which has developed a robust array of therapy EBPs in its Medicaid benefit, reimburses EBPs at up to double the non-EBP rate. CBH recommends that the SPA modify the reimbursement rate for IIHS EBPs at a more significant differential to account for the costs associated with certification, training, supervision and reporting associated with an EBP model.

7. Strengthen the expressive therapies model (beginning p. 33).

a. **Allow care delivery and credentialing by OMHC**. The proposed SPA credentials individual practitioners, not clinics. This is a barrier to robust participation because there is no infrastructure of facility supporting the individual or creating an EBP credentialing pipeline. We recommend allowing OMHC to credential as eligible provider, with mechanism such as putting the clinician with EBP certification on the Medicaid claim as a rendering professional. Creating defined role for OMHC will strengthen EBP program infrastructure and enhance continuity in the face of individual staff turnover; OMHCs can put new hires in pipeline, etc.

b. **Transparency**. The expressive therapy provider directory should be publicly available via a public-facing statewide website or available promptly upon request from the public to the Behavioral Health Administration.

c. **Create consistent and adequate rates.** The proposed SPA indicates, "the rate for this service has been aligned with the Medicaid rate for individual practitioners" (page 60). However, rates for certified EBP expressive therapy are lower than rate for non-EBP therapy in OMHCs. For example, a 45-minute therapy session is reimbursed as an expressive therapy at rates between $93.81 - $103.19, while an OMHC receives $161.87 for a 45-minute child therapy session. Normally, higher

[4] See Optum, "Fee Schedule" (ACT at $1821.77 and MTS at $12921.66).

patient acuity and higher provider training should support a higher reimbursement rate. For these reasons, CBH recommends setting expressive therapy EBP rates at least 50% higher than non-EBP therapy rates in OMHCs.

CBH appreciates the Department's attention to reforming the 1915(i) array of services to increase access to care for Maryland children, and we look forward to supporting the Department's continued work in this area. If you have any questions about these comments, please feel free to contact me at shannon@mdcbh.org.

Sincerely,

Shannon Hall
Executive Director

cc: mdh.mabehavioralhealth@maryland.gov