Report on Implementation of the New Foster Care Provider Rate Structure

Maryland Department of Human Services

Completed pursuant to the 2024 Joint Chairmen's Report, Page 146-147

July 31, 2024

REPORT REQUIREMENT

This report is hereby submitted in response to the following reporting requirement found under the 2024 Joint Chairmen's Report, page 147:

> *The report shall include details on the use of funding included in the fiscal 2025 allowance for this purpose, including the individual purposes that this funding will be used to support, and an updated timeline on when each component of the new provider rate structure will be implemented. The report shall also include an update on the approval of amendments to the State Medicaid Plan to allow for clinical care costs to be eligible for reimbursement and when federal reimbursement will be able to be first sought for these costs. In addition, the report shall discuss the use of the funding for provider rate increases including how the funding included in the fiscal 2025 allowance will be used in conjunction with funding supporting rate reform or otherwise. The report shall be submitted by July 1, 2024, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.*

Source: 2024 Joint Chairmen's Report, page 147

USE OF FUNDING INCLUDED IN FY 2025 ALLOWANCE AND UPDATED TIMELINE

The Department of Human Services (DHS) and the Quality Service Reform Initiative (QSRI) workgroup have continued to focus on the key activities necessary to implement this new placement provider rate structure, including a proposed Medicaid State Plan Amendment. The work of DHS and the QSRI workgroup has remained focused and on-track.

Rate Reform

The FY2025 allowance includes funding to support DHS's implementation of rate reform for residential child care (RCC) providers. The RCC provider rates are set by the Interagency Rates Committee (IRC). The new RCC rate structure will be implemented effective October 1, 2024, with a goal of integrating all of the quality and performance components in FY2026. DHS contracted with Public Consulting Group (PCG) and the University of Maryland Innovations Institute for the development of the new class-based rate structure and requirements for RCCs. The two main cost drivers for the new rates are personnel (staffing, salaries, and benefits) and operating costs (rent, travel and transport, training, contracted services, administrative costs, and other). For personnel, the model used the highest wage between either the weighted average reported from the IRC Budgets or the Bureau of Labor Statistics weighted average.

The new RCC standards implemented within each class necessitate higher rates (minimum staffing and service requirements outlined in the table below). Even though programs within the same class may serve children with different needs, the costs are similar regarding wages, ratios, training, and supervision. Programs in

classes 3-6 have additional personnel and/or operating costs associated with supervision, security, and care management. The additional fiscal allowance enables RCC providers to receive rates that are commensurate with the new expectations and enables providers to compensate their professional and allied staff with competitive wages. *See Class Descriptions Information below.*

The new placement provider rate structure for Child Placement Agencies (CPA) with treatment foster care (TFC) and independent living (IL) programs is in progress and scheduled for implementation in FY26. Implementation will include collecting performance measures as part of a continuous quality improvement (CQI) process and data collection specific to the fiscal impact of the rate structure.

	FY25 Class Rate (Clinical & Direct Care)	**Direct Care Staffing Ratio (Staff : Youth)**		**Additional Requirements** (In addition to standard requirements of meeting all statutory, regulatory, and contractual requirements of license; participate in data collection and reporting process; and maintain at least two awake staff always)
		Awake	**Asleep**	
0: Pre-QRTP	$433.46	1:6	1:7	N/A**
99: I/DD Legacy	$606.65	1:3	1:4	N/A**
1: Serve Youth with Significant Behavioral Health Service Needs (Class 1 or 1b)	Class 1 (6 or more beds): $739.88 Class 1b (5 or fewer beds): $808.18	1:4	1:5	• Serve children with significant behavioral health service needs • 1:10 ratio of care manager to youth • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Meet Maryland's requirements for QRTPs
2: Serve Youth with Intensive or Specialty Behavioral Health Service Needs (Class 2 or 2b)	Class 2 (6 or more beds): $892.63 Class 2b (5 or fewer beds): $986.54	1:3	1:4	• Serve children with intensive and/or specialty behavioral health service needs • Maintain 1 floater, direct care staff outside of ratio during awake hours • 1:8 ratio of care manager to youth • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Clinical/behavioral health supervisors have at least 2 years of experience providing similar services and/or working with this population (preferred for all clinicians) • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment • Meet Maryland's requirements for QRTPs

	FY25 Class Rate (Clinical & Direct Care)	Direct Care Staffing Ratio (Staff : Youth)		Additional Requirements (In addition to standard requirements of meeting all statutory, regulatory, and contractual requirements of license; participate in data collection and reporting process; and maintain at least two awake staff always)
		Awake	Asleep	
3: Serve Youth with High Intensity I/DD Service Needs (No Behavioral Health Services)	$1,313.75	1:1	1:1	• Serve children with high intensity intellectual and/or developmental disability service needs • Maintain 1 floater, direct care staff outside of ratio during awake hours • Provide transportation to any clinical or behavioral health services required (not required to provide the services directly) • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment
4: Serve Youth Needing High Intensity Medically Fragile Services	$1,581.55	1:1	1:1	• Serve children with high intensity medically fragile service needs • 24/7 nursing services provided to meet the physical health needs of children and youth served • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment • Provide transportation to any clinical or behavioral health services required (not required to provide the services directly)

	FY25 Class Rate (Clinical & Direct Care)	Direct Care Staffing Ratio (Staff : Youth)		Additional Requirements (In addition to standard requirements of meeting all statutory, regulatory, and contractual requirements of license; participate in data collection and reporting process; and maintain at least two awake staff always)
		Awake	Asleep	
5: Serve Youth Who Have Experienced/At-Risk for Commercial Sexual Exploitation	$1,996.66	1:1	1:1	• Serve children who have experienced or are at-risk for experiencing commercial sexual exploitation (CSE) or human trafficking, as screened or assessed with State-identified tools, who have significant or intensive behavioral health service needs • Maintain 1 floater, direct care staff outside of ratio always • 24/7 nursing services provided to meet the physical health needs of children and youth served • Direct care staff have specialized training, qualifications, and/or experience in working with the specific population of children and youth served or complete specialized training within 180 days of employment • Must document that the youth have experienced CSE or are at-risk for CSE based on State-approved tool • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Clinical/behavioral health supervisors have at least 2 years of experience providing similar services and/or working with this population (preferred for all clinicians)

	FY25 Class Rate (Clinical & Direct Care)	Direct Care Staffing Ratio (Staff : Youth)		Additional Requirements (In addition to standard requirements of meeting all statutory, regulatory, and contractual requirements of license; participate in data collection and reporting process; and maintain at least two awake staff always)
		Awake	Asleep	
6: Serve Youth with the Highest Intensity Behavioral Health and Intensive I/DD Service Needs	$2,099.80	2:1	1:1	• Serve children with the highest intensity behavioral health service needs and co-occurring intensive intellectual and/or developmental disability service needs • Maintain 1 floater, direct care staff outside of ratio during awake hours • 1:8 ratio of care manager to youth • Provide minimum of 8 hours of clinical, behavioral health, allied, and/or expressive therapies or interventions weekly (averaged per month) • Clinical/behavioral health supervisors have at least 2 years of experience providing similar services and/or working with this population (preferred for all clinicians) • Meet Maryland's requirements for QRTPs

UPDATE ON APPROVAL OF AMENDMENTS TO STATE MEDICAID PLAN

DHS is meeting with the Maryland Department of Health (MDH) as part of the QSRI Workgroup and in separate meetings to draft and submit the necessary Medicaid State Plan Amendment(s) to the U.S. Centers for Medicare and Medicaid Services with a goal of bringing Medicaid claiming for all eligible services and providers as quickly as possible. Medicaid claiming will provide a federal supplement to the services that were provided using 100% General Funds. The plan includes proposing regulations in December 2024 for an effective date of July 1, 2025.