CLASP

Policy solutions that work for low-income people

Memorandum

To: Renee Ensor-Pope, Jaqueline Duval-Harvey, Eugenia Greenhood
From: PATH Team at CLASP
Date: April 1, 2020
Re: Policy Options to Reduce Service Cliffs/Gaps for Transition Age Youth

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SUMMARY

One of the goals of Prince George's County's CLASP work is to align eligibility criteria and definitions across the child and adult systems to reduce gaps and cliffs for young people currently accessing services. The Prince George's County PATH team developed a comparison chart of medical necessity criteria for all currently available behavioral health services for the transition-age youth age span in the county. Based on this comparison, the team identified 5 areas where the medical necessity criteria or payment structure differed for children versus adults: psychiatric rehabilitation program (PRP), mobile crisis and stabilization services, residential rehabilitation, mobile treatment, and targeted case management. In addition, stakeholder conversations across the system of care (SOC) and Youth Homelessness Demonstration Project (YHDP) identified access to app-based telehealth and telehealth by text as high priority for transition-age youth. This memo provides an overview of policy options for improving access, payment, or the structure of these services for transition-age youth and concludes with recommendations for priorities that achieve high impact and best respond to stakeholder feedback.

Policy Option 1: Extend the adult tiered case rate structure for PRP services to 16 and 17-year olds

Currently, children's PRP services are reimbursed based on a case rate that covers three visits per month. As a result, most providers do not provide more than three visits, regardless of need. Adult PRP services are reimbursed using a tiered case rate that is tied to level of need, giving providers more flexibility to adjust the number of visits based on client need. This proposal would extend the adult tiered case rate structure for PRP to 16 and 17-year olds to align their PRP service experience with that of young adults 18-24.

Psychiatric Rehabilitation Program (PRP)	**Target Population**	**FY19 Number of TAY receiving service**	**Cost per youth billed to Medicaid**	**Additional Cost per Youth ages 16-17**	**Total additional cost per year**
	16 and 17 year olds currently receiving PRP services	314 (ages 16-17) 422 (ages 18-24)	Cost per youth 16-17: $2615.50 Cost/person ages 18-25 (tiered case rate): $4551.12	$1935.62	$607,784.68

Impact Summary: The proposed change will increase the cost for this population but would also theoretically improve the flexibility of PRP services to meet the needs of transition-age youth. This change would impact a

relatively small number of 16 and 17-year olds who currently receive PRP services under the child billing structure (approximately 300 youth annually). We did receive some pushback from providers about this change, who indicated that it might be more beneficial to extend the child billing structure to young adults. They felt that 16 and 17 year olds would struggle with the more flexible structure currently offered to 18-24 year olds, and in fact they felt that 18-21 year olds struggle with this structure.

Policy Option 2: Make the currently grant-funded mobile crisis and stabilization services a Medicaid billable service for youth through age 25.

Data from the National Survey on Drug Use and Health (NSDUH) indicate that 8000 youth ages 18-25 in Prince George's County felt that they needed mental health services at some point in the prior year but did not receive them. Half of these young people eventually found their way to treatment, leaving 4000 youth in the county who report unmet mental health needs in any given year. Currently, Prince George's County is providing grant -funded mobile crisis and stabilization services to children up to age 18. This proposal would both extend the eligible age range to include transition- age youth 18-25 and make mobile crisis and stabilization services a Medicaid billable service.

Mobile Crisis and Stabilization	**Target Population**	**FY19 Number of TAY receiving service**	**Cost per youth billed to Medicaid**	**Cost to double Current Capacity**	**Cost to reach 50% of target population**
	4000 TAY/year ages 18-25 who perceive a need for MH services but never receive them				

Impact Summary:

Policy Option 3: Make transition-age youth a priority population for residential rehabilitation

According to NSDUH, approximately 6900 transition age youth experience serious mental illness (SMI) in the county each year. The county also estimates that between 5000 and 6000 young people experience or are at risk of homelessness in the county each year, and just over 1000 of them are experiencing SMI. Currently, residential rehabilitation is an adult service; the admission criteria include a diagnosis of serious mental illness which defines the priority populations for this service. The proposed change would amend the medical necessity criteria for residential rehabilitation to make transition-age youth 16-24 a priority population for this service.

Residential Rehabilitation	**Target Population**	**FY19 Number of TAY receiving service**	**Cost per youth billed to Medicaid**	**Cost to double Current Capacity**	**Cost to reach 50% of target population**
	1111 TAY experiencing SMI and homelessness	46	$1139.92	$52,436.32	$633,225.56

Impact Summary: Residential rehabilitation is a relatively inexpensive service that if scaled could have a significant impact for transition age youth experiencing homelessness in the county. The program's reach can be increased substantially with relatively little impact to cost; it would also likely reduce the use of more expensive inpatient services by young people experiencing homelessness. Making transition age youth a priority population for residential rehabilitation is likely to have moderate to high impact in the county.

Policy Option 4: Develop TAY specific medical necessity criteria for mobile treatment services

The PATH team and NSDUH estimates, somewhere between 22,500 and 24,000 youth ages 16-25 in the county experience any mental illness (AMI) every year. Around half, or 12,000 young people receive some form of mental health services in the county. Currently, mobile treatment services are available on a limited basis to adults who are considered "hard to treat" and have been unsuccessful with traditional, in office treatment models. The proposed change would create TAY specific medical necessity criteria for mobile treatment services to allow TAY to access on-going treatment in the community.

Mobile Treatment Services	**Target Population**	**Current Number of TAY receiving service**	**Cost per youth billed to Medicaid**	**Cost to double Current Capacity**	**Cost to reach 50% of target population**
	10-12,000 TAY/year with unmet behavioral health needs	92 (6 ages 16-17; 86 ages 18-24)	$4338.19	$399,114.21	$26,029,140

Impact Summary: Stakeholder conversations in the county indicate that there is high interest from youth in increasing access to mobile treatment services. Mobile treatment services are currently significantly more expensive per youth than traditional outpatient services ($1497.43/youth), but significantly less expensive than inpatient hospitalization ($14,846/youth). It may be possible to construct TAY specific medical necessity criteria to substantially increase reach while reducing costs for this subpopulation. Developing TAY specific medical necessity criteria that make mobile treatment broadly accessible to TAY without first failing more traditional outpatient treatment has the potential to achieve high impact for transition-age youth by increasing access to services and reducing the need for higher cost inpatient services.

Policy Option 5: Expand access to targeted case management for transition age youth by aligning medical necessity criteria for children and adults.

Currently, medical necessity criteria for targeted case management differ for children and adults. The admission criteria for children require a history of multiple hospitalizations or recent inpatient stay, which is not a requirement for adults. The continued stay criteria for children also require that the family, custodian, or guardian is actively involved in treatment (unless contraindicated), which is not required for adults. A child can also be discharged because of family non-participation. The proposed change would align child and adult criteria for transition age youth by making the admission, continued stay, and discharge criteria for 16 and 17-year olds the same as the criteria for adults by removing the requirements for recent inpatient stay and family involvement.

Targeted Case Management	Target Population	Current Number of TAY receiving service	Cost per youth billed to Medicaid	Cost to double Current Capacity	Cost to reach 50% of target population
	10-12,000 TAY/year with unmet behavioral health needs	38	$1001.10	$38, 041.97	$6,006,600

Impact Summary: Targeted case management currently reaches a relatively small number of transition-age youth; aligning the medical necessity criteria across the transition age youth range would help to ensure continuity of targeted case management services and ease access to targeted case management services for 16 and 17 year olds by removing the requirement of multiple or recent hospitalizations. Targeted case management is a less expensive service than traditional outpatient services; expanding access to this service has the potential to substantially increase access to services at lower cost.

Policy Option 6: Make app-based telehealth and telehealth by text Medicaid billable services for transition age youth.

Currently, Maryland telehealth statute requires that reimbursable telehealth services be in real time and enable the patient to see and interact with the health care provider by video. Eligible services include diagnostic interview, individual therapy, family therapy, group therapy for the individual, outpatient evaluation and management, outpatient office consultation, initial inpatient consultation, and emergency department services. Current statute makes no provision for (and in fact explicitly prohibits) reimbursement for app-based telehealth services or telehealth by text. The proposed policy option would change current statute to permit Medicaid reimbursement for app-based telehealth services and telehealth by text.

Telehealth by app and text	Target Population	Current Number of TAY receiving service	Projected cost per youth billed to Medicaid	Projected cost to reach 50% of target population
	10-12,000 TAY/year with unmet behavioral health needs	0	Current annual cost (private market): $1800-$3800 per person/year Scale pricing for daily contact (NHS, England): $138.60 per youth per year	$831, 600

Impact Summary: Conversations with stakeholders in the county indicate that expanded access to app-based

telehealth and telehealth by text is a high priority. Maryland's current telehealth law expires in September of 2020, which opens an opportunity for advocacy to expand and improve the law. At the federal level, the current COVID-19 crisis has prompted CMS to relax telehealth billing rules in Medicare to increase access to telehealth, including mental health services. Given that app-based telehealth and telehealth by text at scale are significantly less expensive than traditional outpatient services and are responsive to several needs articulated by transition-age youth in the county, this change would achieve high impact.

Inpatient (annual): $14,846/youth	**Low Impact**	**High Impact**
High Cost *Traditional Outpatient (annual): $1497.43*	• PRP	• Mobile Treatment • Telehealth by Text (Private Market)
Low Cost	• Residential Rehab • Targeted Case Management	• Telehealth by Text/App (Scale)

Key Considerations and Takeaways

The six policy proposals included in this memo include reforms to payment structure, alignment/amendment of medical necessity criteria, and statutory change. There is some opportunity to address all these options, but the team will likely need to prioritize and focus on a smaller number of options in the near term. Based on our review of available data, stakeholder feedback, and our understanding of momentum/opportunity at the federal and state level, we recommend:

1. Making app-based telehealth and telehealth by text Medicaid billable services a high priority for legislative change. Given that Maryland's telehealth law is slated for review and update in the second half of 2020, now is an ideal time to develop an advocacy plan and proposed updated legislative language in support of these changes.
2. Expanding the age range for mobile crisis and stabilization, making mobile crisis and stabilization a Medicaid billable service, and developing TAY specific medical necessity criteria for mobile treatment services are high priority for regulatory change. Several other states, including Connecticut, Oklahoma, Nevada, New Jersey, and Illinois have already made mobile crisis and stabilization a Medicaid billable service for young people through age 25. Access to mobile treatment for transition-age youth by developing criteria that does not require "failing" traditional outpatient treatment first can potentially increase access to needed treatment while reducing costs of this service.

3. The other proposed policy options merit consideration in the context of other initiatives in the county. For example, expanding residential rehabilitation and targeted case management potentially dovetails well with YHDP project goals. Changing the payment structure for PRP would likely have the lowest impact in terms of number of youth of all of these proposals, but might be a comparatively easy lift as a result.
4. Next steps include finalizing policy priorities, developing policy statements and legislative language for priority options as appropriate, and developing a strategy for proposing priority changes to the appropriate parties. The CLASP team is here to support with these next steps.