Integrated Children's Services Initiative Frequently Asked Questions
July 20, 2005

1. **What is the rationale for this change?**

   Last year the Department began the Integrated Children's Services Initiative to ensure that all children have access to the comprehensive range of high quality services available through all public systems, regardless of how the child enters the system. The three reasons that the Department is moving toward integrated children's services are: 1) to be child and family focused by enhancing access to all services funded by the Department; 2) to build systems that serve and protect children through increased accountability; and 3) to maximize the use of federal rather than state or local funding for services that are eligible for federal reimbursement.

2. **What is the time frame?**

   The initiative is being phased-in over several years, beginning in January 2005 with providers in five counties. In fiscal year 2005-06, we will continue to phase in providers in all counties. The Department acknowledges that not all behavioral health services will be identified and not all eligible providers will be enrolled by July 1, 2005 or even during fiscal year 2005-06 and the initiative is therefore expected to continue in subsequent fiscal years.

3. **What principles guide this initiative?**

   The following principles guide the integrated children's services initiative:

   - Creating an integrated service system for children to provide access to a continuum of child welfare and juvenile justice services;
   - Putting the child's needs first in providing timely access to behavioral health treatment services to children in the child welfare and juvenile justice systems;
   - Delivering behavioral health services through coordinated planning processes that involve the behavioral health, child welfare and juvenile justice systems;
   - Paying for medically necessary behavioral health treatment services through the Medical Assistance Program for children who are eligible for Medical Assistance;
   - Enhancing the quality and monitoring of the delivery of behavioral health treatment services to assure successful treatment outcomes;
   - Recognizing that the behavioral health treatment services available to children in the juvenile justice system are delivered in the context of providing balanced attention to the protection of the community, holding children accountable for offenses committed, and to the development of competencies to enable children to become responsible and productive members of their communities;

- o Recognizing that the array of services available to children in the child welfare and juvenile justice systems is designed to provide for the children's care, protection, safety and wholesome mental and physical development.

4. What are the applicable program standards and rules to this initiative?

This initiative will continue to be guided by existing Department regulations, policies and procedures. The following Office of Medical Assistance bulletins apply:

- o 01-93-04 – Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals under 21 Years of Age;
- o 1157-95-01 – Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under the Age of 21;
- o 1165-95-01 – Update – Joint Commission on Accreditation of Health Care Organization (JCAHO) Accredited RTF Services;
- o 1153-95-01 – Accessing Outpatient Wraparound Mental Health Services Not Currently included in the Medical Assistance Program Fee Schedule for Eligible Children under 21;
- o 17-02-04 – Residential Treatment Services Provided in a Secure Setting

In addition, in HealthChoices counties, the contractual agreement between counties and each provider will continued to be negotiated consistent with current policy and procedure.

5. What is medical necessity and how is it applied?

Determination of medical necessity will continue to be guided by existing Department policies and procedures.

- Medical Necessity is a clinical determination based on the presenting facts in each individual child/adolescent's situation to establish a service or benefit which will and is reasonably expected to:
  - o prevent the onset of an illness, condition, or disability;
  - o reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability;
  - o assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individual of the same age.

- For children, the Department has developed medical necessity criteria for:
  - o Inpatient Hospitalization
  - o Outpatient Treatment
  - o Partial Hospitalization
  - o Family-Based Mental Health Services

  - o Residential Treatment Facility placement
  - o Behavioral Health Rehabilitation Services

- Medical Necessity is based on the severity of the disorder in relation to the intensity or level of the service recommended. It is determined by reviewing current functioning as well as a history of the child's previous level of functioning and previous BH services provided; all of the factors involved in the individual child/adolescent's case; whether the proposed service is expected to result in improvement of the condition and is the "least restrictive" service appropriate to meet the behavioral health needs of the child.

6. Who may appeal a denial of medical necessity and how are services funded pending the appeal?

A child over the age of 14, the parent of a person under the age of 18 or an agency who has been awarded custody of a child may appeal a determination of medical necessity which results in the denial, change or reduction of services. The appeal must be requested within 30 days.

When an initial request for authorization of a service is submitted, and the service is determined not to be medically necessary, a county may pay for services pending the outcome of the appeal using child welfare program funds. If the appeal determines that services are not medically necessary, then the county may continue to pay for services using child welfare program funds. If the appeal determines that services are medically necessary, then the services will be reimbursed through the medical assistance program retroactive to the date of the denial. Consistent with current policy and procedure, the provider must reimburse the county for any payments made from the date of denial to the date of the appeal determination. The provider will be then be paid through the Medical Assistance Program.

If services that a child has been receiving are reduced or terminated and an appeal is filed within 10 days of the date of the notice, the Medical Assistance Program continues to pay for the services pending the outcome of the appeal. If the appeal reverses the reduction or termination, Medical Assistance continues to pay for the services. If the appeal process results in a determination that services are no longer medically necessary, the county children and youth agency or juvenile probation office may pay for these services through child welfare program funds.

A child-serving agency may assist a child's family in the appeal process.

7. What are the steps a provider must take to become enrolled as a MA provider?

To be eligible to enroll in the Medical Assistance Program, practitioners in Pennsylvania must be licensed and currently registered by the appropriate State agency. Out-of-state practitioners must be licensed and currently registered by the appropriate agency in their state, and must participate in that state's Medicaid

program. To enroll, providers must complete a base provider enrollment form and any applicable addenda documents dependent on the provider type. Specific information, including enrollment forms, may be found on the Department's website. www.dpw.state.pa.us

8. How are rates established?

Statewide providers will need to negotiate rates with several entities. For non-HealthChoices, fee-for-service counties, Department rate-setting personnel in the Office of Medical Assistance Programs will negotiate rates with each provider. In HealthChoices counties, providers negotiate rates directly with each managed care organization with which they participate.

9. Will the first Managed Care Organization established rate become the fee-for-service rate? Will the Department review established rates after a year based on the Joint Financial Schedules to determine if a rate adjustment is needed?

For Fiscal Year 2004-05, the Department will accept the first managed care established rate as the fee-for-service rate. For Fiscal Year 2005-06, the Department may renegotiate the fee-for-service rate.

10. What is the process for requesting an enhanced rate through fee-for-service?

Medical Assistance Bulletin 1153-95-01, entitled Accessing Outpatient Behavioral Health Services Not Currently Included on the Medical Assistance Program Fee Schedule for Eligible Recipients Under 21 Years of Age, includes the parameters for requesting an enhanced rate. This bulletin may be found on the Department's website at www.dpw.state.pa.us. Questions may be directed to the Provider Helpline at 1-800-537-6682.

11. Will providers be at risk for services subsequently found not to be Medical Assistance eligible?

Those services that do not have a qualified treatment component, are delivered by a provider not enrolled in the Medical Assistance Program, are provided to an individual who is not eligible for Medical Assistance, or are determined to be not medically necessary will continue to be reimbursed consistent with the child welfare funding program (for residential programs, see Medical Assistance Bulletin (MAB) 1157-95-01 – Mental Health Services Provided in a Non-JCAHO Accredited Residential Treatment Facility for Children Under the Age of 21, p. 12, and MAB 1165-95-01, Update – Joint Commission on Accreditation of Health Care Organization (JCAHO) Accredited RTF Services, p. 3).

12. What obligations will the Medical Assistance Program, including HealthChoices behavioral health entities, have to respond to the timeliness standards required under the Juvenile Act?

One of the principles that guide this initiative is to provide children who are alleged or adjudicated dependent or delinquent with access to timely behavioral health treatment services. If all agencies involved in arranging for services to a child work cooperatively, the Department expects that determination of medical necessity will be made within the timeframes established in the Juvenile Act.

13. Does the Department intend to allow Council on Accreditation (COA) and Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation for residential services?

Providers who are already accredited as COA or CARF can request a waiver of the current requirement that accreditation be awarded by JCAHO. RTFs will not be required to become accredited in order to participate in the Medical Assistance program. However, all accredited residential treatment facility providers are bound by the following OMAP Bulletins:

- 01-93-04 – Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals under 21 Years of Age;
- 1165-95-01 – Update – Joint Commission on Accreditation of Health Care Organization (JCAHO) Accredited RTF Services;
- 53-01-01 – Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities; and
- 53-03-01 – Process to Handle Residential Treatment Facility (RTF) Reports of Death, Serious Injury or Attempted Suicide (Serious Occurrences)
- 17-02-04 – Residential Treatment Services Provided in a Secure Setting

14. Can a provider offer both residential treatment facility (RTF) services to children who need that level of care and child welfare and juvenile justice services without a behavioral health treatment component to other children at the same location?

In order to be paid for both an RTF level of care and a level of care that does not include a behavioral health treatment component, the programming for the treatment and non-treatment levels of care must be different. A provider or county may not claim Medical Assistance payment for one child and child welfare payment for another child for the same services. Treatment costs are not eligible for Title IV-E funding, and non-treatment costs are not eligible for Title XIX funding. The same services cannot be treatment for one child and non-treatment for another child.

In an accredited RTF, the “treatment beds” must be separate from – i.e., in a distinct unit – the “non-treatment beds.” “Treatment beds” and “non-treatment beds” may not be intermingled. Both Title XIX funds and Title IV-E funds may be used to pay for

services provided to different children by the same accredited RTF if the RTF provides both treatment and non-treatment – i.e., placement maintenance – services, as long as Title XIX funds are used only to pay for treatment services for one group of children and Title IV-E funds are used only to pay for placement maintenance funds for another group of children.

In a non-accredited RTF, whether “treatment beds” and “non-treatment” beds may be intermingled depends on the clinical needs of the children being served. All non-treatment costs – i.e., placement maintenance costs – provided in a non-accredited RTF are eligible for Title IV-E funding.

15. When a child is placed in a residential treatment facility (RTF) and the service is determined to no longer be medically necessary, but the child requires continued placement services, must the child be relocated? If not, what is the mechanism for reimbursement?

If the provider offers both RTF services and child welfare services without a behavioral health treatment, as described in response to Question 14, then the child may be moved to the non-treatment component of the program, and the services to the child are reimbursable under Title IV-E and Act 148 within the county’s allocation. If the provider offers only RTF services, as stated in Bulletin 00-05-05, Integrated Children’s Services Initiative, placement in an RTF after RTF level of care is determined to be not medically necessary may be reimbursed using Act 148 funds within the county’s allocation.

16. During HealthChoices implementation in 1999, "transitional" authorization for services for individuals who were authorized for a particular level of care (funded by MA-FFS) was permitted in order to assure continuity of service in the absence of information needed to determine medical necessity. Will the same standards apply during this transition?

No, during the transition from Fee-for-Service to HealthChoices, the child’s current level of care had been authorized by the Office of Medical Assistance Programs, and the HealthChoices managed care organizations were required to honor that authorization. For children placed in a facility that enrolls as a provider through Integrated Children’s Services Initiative, the medical necessity of the current level of care has not been determined. Attached is a one-page chart that outlines the steps that the sending county and provider must take to obtain authorization for children in a facility at the time the provider transitions to Medical Assistance funding.

17. Can accredited agencies have a psychologist conduct the evaluation for entry into a residential treatment facility (RTF) with the State’s HealthChoices waiver?

Federal regulations require that placement in an accredited RTF must be recommended by a psychiatric evaluation.

18. In the event that significant numbers of parents of children involved with the child welfare or juvenile justice system are not able or willing to participate in treatment in the manner that is expected in the behavioral health system, will IPRO standards be adjusted to reduce the possibility of providers basing their admission decisions in part upon how "compliant" a young person's parents might be?

Parents of children involved in the child welfare and juvenile just systems must be given the opportunity, consistent with any court-ordered restrictions, to participate in the treatment for their children. Providers may not base their admissions decisions in any part on how "compliant" parents might be in participating in their child's treatment. If a parent is unable or unwilling to participate in the child's treatment despite the provider's efforts to invite the parents to do so, the provider should document both the effort to engage the parent and the parent's inability or refusal to do so in the child's record.

19. What is the role of the Department's Bureau Program Integrity and Bureau of Financial Operations in the Integrated Children's Services Initiative?

Audits by both bureaus will be conducted consistent with policies and procedures that the Department has established to guide this initiative.

20. What if one county agrees to include a provider in their network and another county does not want to include the provider in their network?

The county that does not want to include the provider must demonstrate that there is sufficient access to meet the behavioral health needs of children served in the child welfare and juvenile justice systems as confirmed by the County Commissioners, county children and youth agency, office of behavioral health, juvenile probation office, and local Juvenile Court Judges.

21. Are shelters being converted to be residential treatment facility (RTF) providers?

Some programs that provide shelter care also provide clinical treatment and therefore meet requirements for enrollment in the Medical Assistance Program, either as an RTF or as a different provider type.

22. Why is the supplemental payment based only on the TANF and SSI plus Healthy Horizons without Medicare rating groups (based on county specific member months data for children in substitute care)?

The financing methodology has been adjusted to include all federally eligible rating groups.