

## **Medical Assistance Realignment**

Note: This evolutionary process for transitioning funding for services from state (Act 148) dollars and local match to a more appropriate source, Medical Assistance (federal) and state match, has been the basis of numerous questions, discussions and concerns. This process has been fluid in its development. As the particular needs and challenges of counties have influenced implementation, answers to questions raised during the past several months have been modified. As experiences have been gained and individual counties' needs have been incorporated into the process, additional clarity has been acquired. The process to engage providers and the expectations of services have also varied based on programming scope, the history of private providers and regional experiences.

Given this, the following compilation of questions and answers as gathered in various meetings and locations as noted across the Commonwealth, is not to be construed as the definitive current response of the Department of Public Welfare. It is rather, a running listing of the questions raised through this process and the answers supplied in the time frames as noted. It is presented as the known information as of that moment as recorded by PCCYFS staff. Clarification of current interpretation or direction should be obtained from those individuals identified by DPW, County C&Y/MH/MR systems or other individuals identified by OCYF and/or OMHSAS.

Last updated March 17, 2005

### **Questions raised in Southeast**

**December 22, 2004**

*Answers provided by Richard Gold and Anne Shenberger*

Q. Who are providers billing as of the beginning of January when the process shifts?

A. There will not be significant changes as of January 3<sup>rd</sup>, because in January billing will still be the responsibility of DHS for December services.

February will be the critical billing month to begin billing to CBH. CBH will be advancing providers 3 months payment to avoid a payment crisis.

Timeframes for payment - Jan: Bill DHS for Dec. 2004 services; Jan - July 2005 bill CBH

Q. Who should providers contact beginning January 3<sup>rd</sup> with questions?

A. At this point, contact DHS.

Q. Where should providers turn for day to day details regarding process, questions, and needed information re: CBH?

A. CBH staff will be scheduling meetings with providers. CBH will be assigning clinical case managers to providers.

Q. Is there movement toward a fee schedule for residential services?

A. No. At this point, rates will be provider specific - there will be no uniform rates for the levels of treatment. So for example, a level 2 rate will be different at each agency. Rates (per diems) will be adjusted as program descriptions change.

Providers may submit two sets of rates - one set reflecting the start-up costs from January to June 2005 and one for rates for July 1, 2005 through June 2006. One provider has already done this. Providers will be advised if their rate submission is approved by early January.

"These kids will be reimbursed differently, and treated differently." – This response was offered as part of the discussion as to the scope of HealthChoices managed care within Philadelphia and the realities of the differences which were identified in both funding and service delivery.

Q. Who will providers negotiate with re: rates, deliverables?

A. CBH - but rates are being reviewed now in context of the newly revised and submitted program descriptions.

Q. Will there be an opportunity to discuss the initial packet of information submitted directly with CBH?

A. Right now the rate discussions will take place with Anne and Richard; however, providers will have an opportunity to discuss the rate packet with CBH. A special budget format used by Philadelphia's Office of Mental Health will be distributed to providers.

Q. On what criteria will the rates that providers submitted this week be reviewed?

A. The information will be reviewed as will the rates attached, generally determining if they pass the "smell" test.

Q. Will cost of care issues be realistically considered, since this was not providers' experience with DHS?

A. Yes.

Q. Will additions to the MA fee schedule be made?

A. Yes, additions are being made.

Q. Providers are wary about the shifting of dollars to MA specific to the sustainability of this initiative.

A. If costs are not shifted, DHS will run out of money by March 2005. The DHS has an annualized deficit of \$50 million - \$17 to 20 million is needed to cover the deficit in the current fiscal year. The projected deficit should be covered by the cost shifting of the Group A providers.

In general - the additional benefit that results from the cost shifting is that the counties will not have to allocate local match money required to fund the more traditional child welfare services.

Q. What are other states doing?

A. Almost all other states already are drawing down MA dollars for MH treatment costs for dependent and delinquent children and youth. Pennsylvania has lagged behind in the MA draw down for child welfare services. Conversely, PA has used TANF dollars, unlike other states, to fund child welfare services.

Q. What regulations will providers be expected to comply with?

A. Residential providers must comply with the 3800 regulations. Treatment Foster Care Providers who are folding this program into the new residential level system must comply with the 3700 regulations.

Q. Will providers be expected to comply with DHS standards?

A. Providers, who are accredited and will be able to bill the total program costs to CBH, will not be contracting with DHS, therefore providers do not have to comply with DHS standards. Providers who receive Room and Board payment from DHS will still be held to compliance with DHS standards.

Q. What about providers who do not yet have MH licenses?

A. Some agencies may opt to work through a related party or subcontracting arrangement with another provider. Specific TA and support will be offered Richard Gold noted that he “will be walking providers without a MH license through the process”.

Q. Should providers give up any licenses?

A. No, wait and see how the process unfolds. Even though providers will have a bundled rate, the agency may want to keep a particular license to provide services for clients not being paid for through the bundled rate.

Q. Will providers be expected to immediately comply fully with CBH standards?

A. No, CBH standards will be relaxed during the six-month transition period.

Q. Will providers be given something in writing to inform them about what specific standards will be relaxed?

A. Each provider will need to be treated individually based on what their needs are and the specifics of the programs/services delivered. There will not be a definitive set of standards that will be relaxed. The accommodation will be done on an as needed basis.

Q. What about accreditation expectations/requirements?

A. JCAHO accredited providers must comply with those standards.

Q. Who will determine the level of care a child will receive?

A. The provider to whom the child is referred will determine the level of care needed.

Q. Does CBH need client specific information?

A. Yes, CBH needs lists of children receiving services under a licensed or non-licensed program. CBH will load the names in their database for billing purposes.

Q. What scope of seclusion and restraint requirements apply?

A. At present, it depends upon accreditation status. This will be reviewed further given the access to MA dollars. Seclusion is not permitted in PA.

Discussion: The RCTF Program Description Document was distributed. Richard Gold indicated that a provider had compiled the template and that CBH had reviewed it.

According to Richard Gold, CBH was pleased with the template.

Gold also cautioned providers that the program descriptions they submit should include levels of treatment and staffing, but not educational services.

Q. What about the use of DSM IV “V” codes for diagnoses and billing?

A. No V codes should be used for billing, only Axis I & II. MR only billing is not acceptable.

Q. What is the status of treatment foster care programs?

A. Some "A" list agencies with TFC programs will include the TFC program as part of their levels of care. Providers will be given the option of whether to fold in the treatment

foster care based on their level of comfort in doing so. Again, these programs will be subject to the 3700 regulations.

Q. What factors determined whether an agency would be included in the first round for realignment efforts?

A. Providers who have residential services with a MH/DA component were targeted first, particularly those with substantial DHS contracts. Not all residential providers are being asked to shift costs to MA. There are a number of providers who do not provide MH or D&A services - these providers will continue to be reimbursed through the child welfare funding streams as is current practice.

A second group of providers will be targeted for realignment next year - between January and July 2005. These agencies are identified as "Group B" agencies. This group will be identified on individual county needs. No child welfare or juvenile justice only agencies will be in this group - inclusion will be based on whether a MH or D&A treatment component is included in the service array. Some Treatment Foster Care providers will be included in the B group. The expectation is that the process will be completed by June 2005.

Q. What is the status of aftercare services? Shelter services?

A. Aftercare services are on hold at this point. Shelter services - answer not recorded.

Q. What about third party liability issues?

A. The chase and pay protocol should be implemented.

Q. What is happening with non-Philly kids?

A. State level discussions are taking place relevant to this issue.

Q. What about the use of Family Based Service Models?

A. Currently, there are no plans to use MST as a pure model.

Q. Who will enroll kids in MA?

A. DHS will do MA enrollment. Efforts are underway to expedite the process. Those kids who are not MA eligible will go directly to CBH.

Q. What if the feds disallow costs, will the state require reimbursement from the providers for the disallowed costs?

A. Richard Gold stated, "I know of no time where the state went to the providers."

Q. Providers still have concerns about BFO and BPI?

A. BPI has delegated all of its auditing responsibilities to CBH for the last six years.

Q. The state may not come to providers, but CBH has come back to providers. MCO's have been held harmless for federal disallowance, so if CMS does an audit where does that leave providers?

A. Providers are definitely held accountable for providing services that are in the program descriptions. Providers must have a record that provides evidence that services have been provided by credentialed individuals.

Provider Comment: It is critical that CMS buy in to the program descriptions.

Q. Will technical assistance be available for developing a standard for case notes?

A. The CBH director of clinical care case managers will sit down with any provider or group to discuss clinical standards.

Discussion: Ann and Richard met with Judge Myrna Field to discuss the MA realignment process. Judge Fields is interested in the details of provider programming and rates.

Q. How will information be circulated among providers?

A. E-mail

Next Steps;

1. Meeting with CBH
2. Late January meeting with Affected Providers
3. Rumor control.

## Questions raised in Southeast (Philadelphia)

February 14, 2004

Answers provided by Richard Gold and Anne Shenberger

Q. Has the state looked at any other models of using MA dollars to fund child welfare services that could be replicated in Pennsylvania? Are there any other models that we can replicate? Is MST going to be the approved family based treatment model?

A. Ann Shenberger responded, "We are not breaking any new ground here." She noted that Pennsylvania is the last state in the nation to use MA dollars to fund some child welfare services. The state has looked how other states use MA dollars. Ann has specifically looked at New York's system.

Delaware County is looking at making MST the approved treatment model.

Pennsylvania is the 50<sup>th</sup> state out of 50 states in the use of Medicaid funds for child welfare and juvenile justice – we are even behind Mississippi.

Q. Is this shift in funding raising a red flag with the feds?

A. The feds are most concerned about the use of MA dollars to fund targeted case management services and since Pennsylvania does not use this service, concerns are minimized. The feeling is this is something PA should have done a long time ago; PA is not raising new ground but rather following what the other 49 states are doing.

Q. How was the second tier of agencies to participate in MA realignment identified?

A. The "B" list (second tier) of agencies is essentially an extension of the first group of identified participants ("A" list). The "A" list providers were identified as those having large DHS residential contracts that were not receiving maximum MA reimbursement. The "B" list providers were identified as agencies from throughout the state that have large residential service contracts with the five-county southeast region C&Y agencies. Residential services are being targeted because they have more treatment options which affect larger cost savings.

Q. What is happening in other parts of the state?

A. Each county is determining what it needs to do and how and to what extent it will participate in MA realignment. The NE region has identified 18 providers that they will meet with to discuss realignment. Blair County has identified 15 providers to discuss MA realignment with. Other counties are saying that we have to do more and expand the types of services than we are currently looking at as MA reimbursable. The level of urgency among counties differs, but it is urgent for everyone to be on track by July 1, 2005.

Q: What are the goals in the next phase?

A: Going out to the SE suburban counties and looking at them with relation to DHS - met with Magellan in Delaware County today. They are interested in seeing what CBH has approved but they are not obligated to accept what CBH has done but it looks like it will be very close –they do not want to reinvent the wheel. We have been up to Bucks County a number of times and we are trying to streamline the process to make it easier for providers.

Q. Providers have been informed by Philadelphia Department of Human Services that treatment foster care will not be included in the MA realignment process. Providers were told at our last meeting with you that that treatment foster care services would be reimbursed through MA.

A. As mentioned before, each county has the authority to determine if and how they will participate in MA realignment based on the level of "urgency in the county." DHS determined that treatment foster care services would not be included in the realignment process at this time. The other four SE counties are considering shifting treatment foster care cost to Medicaid funding.

Provider Comment: Some MCOs have responded that they do not think treatment foster care has a treatment component sufficient for MA funding.

Q. How do you see the issue of program descriptions playing out?

A. OCYF distributed a program description template to identified providers. Providers returned program descriptions to Richard Gold and he took them for review to CBH (Community Behavioral Health). Once CBH determined that a description was acceptable, Richard took it to the state for review. Magellan is interested in seeing what CBH accepted. Ann Shenberger described her and Richard's job as making it easier for providers to make the transition.

Q: The RTCS (residential treatment continuum of services) hybrid – is it still to be or will it just be a non-JCAHO nomenclature?

A: We are creating a service without trying to disturb the bureaucracy; providers need to create a continuum of service that treats the children/youth served. Ann Shenberger responded that, "We are trying to create a service without disturbing the bureaucracy. There is nothing in the DPW bureaucracy which requires that all services have to be the same." "Whether you are a JCAHO or non-JCAHO, your goal is to create a continuum of services and we will worry about how to fit it into the bureaucracy."

We are looking at Treatment Foster Care in the counties and no decision has been made yet as to what kind of license you will need to provide TFC. In Philadelphia, TFC is not their highest priority. Delaware County is looking at TFC.

Q. What is the status of COA and CARF accreditation?

A. Richard Gold stated that Estelle Richman has decided that as of July 1, 2005 COA and CARF will have the same status as JCAHO accreditation. DPW has sent letters to MCO informing them that the MCO should reimburse accredited agencies for room and board. With regard to non-accredited agencies, room and board will be paid for with child welfare dollars.

Q: Will providers be expected to comply with DHS standards?

A: Unless you are JCAHO/CARF/COA, providers will have a contract with DHS and their standards will apply. The state is talking with DHS and since they are only paying a small portion of the rate asking if they really need these standards? Additional information will be shared as responses are received from DHS.

Q: What scope of seclusion and restraint requirements apply?

A: In Pennsylvania, seclusion is not allowed. We will look at federal policies and their application with CARF/JCAHO/COA.

Q: What about third party liability issues?

A: There is for room and board by Children & Youth; it will be the same domestic relation issues as currently. There are none for treatment for residential except for JCAHO.

Q: What about concerns with BFO and BPI?

A: BPI comes out and acts for the department with respect to programmatic compliance and providers have to answer questions as to the program issues – mostly they are looking at restraint data and not auditing programs.

Comment: Ann Shenberger has or will be meeting shortly with MCOs in the Bucks, Chester, Delaware, and Montgomery counties. Richard Gold stated that DPW is committed to developing a document that clearly sets out parameters for capitation, medical necessity, and levels of care that will be shared with MCOs. Additionally, DPW will develop a uniform definition of "room and board." Marilyn Eckley, Joan Erney, Chuck Terrell, and Richard Gold meet weekly to facilitate communication.

Provider Comment: Providers raised concerns about the rate setting process.

Response: Gold responded that the payor has the authority to negotiate its own rates once a rate is approved for the service by DPW.

Provider Comment: Providers cautioned that MCOs "hang their hats" on the fee for service rate and providers urged that DPW review fee for service rates before moving ahead.

Response: DPW and MCOs are still undecided about a reimbursement methodology. Currently three methods are being considered -

- Actuarial – actuarially different system (Mercer system) – look historically at usage
- Cost base pass through – this is what you pay –this is usage – like program funded – this is what we will pay you for
- Fee for service – provide it and get reimbursed

The decision on what way to fund will be made in the very near future. For counties beginning before July 1, the costs will be built into a special budget category. The goal is to keep the county whole.

Rate from DHS will not be the same rate throughout the state – every payor (CBH, Magellan, CCBH, Value, fee for service, etc) has the opportunity to negotiate its own rate.

Q. What is the status of billing?

A. All program descriptions are in the budget and enrollment is being monitored. "A" list providers will receive a three-month advance next week whether or not their budgets have been approved. DHS is at the table with providers that are not COA, CARF, or JCAHO accredited. Approved program descriptions have had the numbers of levels they can provide capped at three.

For "A" list providers – the 3-month allowances are going out next week whether or not providers have had a budget meeting and whether or not the rate has been accepted.

Meetings with providers and CBH "not that bad" – the questions are routine and providers are told ahead of time by Richard what will be asked and where the issues

may be. DHS is at the table with CBH and is working cooperatively with the process- DHS and CBH are looking at having a maximum of 3 levels of service per agency; some programs will not have levels, the levels will be defined by the program description and everyone to date has been very cooperative. CBH is looking at this as a way to expand services to kids. CBH & DHS & JPO have worked out protocols and procedures so they work better together.

The meeting with Magellan today was the second discussion. Magellan is also viewing this process in a positive way. Magellan also insures Bucks and Montgomery Counties - have met with those counties also. Also have had meeting with Chester County and their MCO CCBH – what providers need to remember is that everyone is on a different learning curve.

What is becoming evident is that the counties are taking responsibility for MA realignment – they are saying talk with us and that they, the county, will deal with the managed care entity – at this point we do not expect any problems with the MCOs, and that includes the multi-billion dollar MCOs. MA realignment is forcing the counties to “walk” together – not just “talk” – in Philadelphia, CBH has had staff in court for the past year – this process will be replicated in every county. This must be ready to go by 7/1/05.

Philadelphia will be on the hook to make sure that a youth is enrolled in MA as soon as possible – if not, Philadelphia has to pay the whole bill – Providers must contact their MCO clinical care manager and state child was placed with them within 24 hours of placement.

Q. Shouldn't OMHSAS work with MCO to set rate?  
A. No, there is not enough time.

Q. Can an agency do both treatment and child welfare services – Can an agency do/provide both treatment and non-treatment services?  
A. Yes - not every youth will have a MH diagnosis and need treatment

Comments from Anne Shenberger and Richard - We are committed to getting a 2/3 page document that defines MA realignment; medical necessity; capitation and how funded; levels of continuum of treatment; room & board; JCAHO/COA/CARF. We are looking at a uniform definition of room and board – take the same items and it is room and board everywhere – rates may not be the same but the definition is – for example – it will say ---room and board means the following items.....

Gold Comment: Interim guidelines are not controlling; program descriptions will be controlling.

Shenberger Comment: We are not about making up programs for the state.

## Questions raised in Allegheny County

February 18, 2005

*Answers provided primarily by Richard Gold*

Q: Series of questions about audit risks.

A: State has engaged CMS and BFO in the early stages of the process to avoid Federal audit issues. Weekly State level meetings are being held to iron out issues and concerns that might trigger audit problems. There will be no amendment to the State Plan because it is believed that reinterpretation of the ten-year old Medicaid Waiver is all that is necessary. Assurances were offered that the State is “not ignoring the audit process”.

Q: How will the split be determined between room and board and treatment?

A: Providers will advise County of the portion of services that are MA eligible. County will determine rate for room and board. MCO will set rate for MA eligible portion. Jim Gavin (CCBH) stated that he wants to assure that “providers are not victimized by” the process.

Q: Have providers in Philadelphia experienced significant cost increases?

A: When you compare the total cost of MA eligible services that are outsourced in addition to provider rates, the increase hasn't been that much. If costs are projected to increase substantially for a particular provider, maybe they were really only providing dependent/delinquent services and should continue doing so.

Q: Will room and board still be eligible for IV-E?

A: Yes. PA is actually behind other states in capturing eligible MA funding.

Q: Does medical necessity have to be determined?

A: Yes. Philadelphia designed a process that responds to the Court's needs in both dependent and delinquent hearings and that meets the fiscal goals without prolonging the court process. Counties will not be redefining medical necessity criteria; rather, they will be simply developing a process to determine eligibility.

Q: Will family treatment costs be built into rates?

A: Yes. The model presented will have more options than the current medical model to incorporate CYF services that are actually behavior health services but don't fit the medical model.

Q: Will rates allow for services to be individualized to meet the specific needs of children/youth?

A: Yes. Philadelphia providers are happy because they can actually amend treatment levels based on individual immediate need.

Q: Are we still looking at 20 days authorization time for non-MCO counties?

A: There is no experience with non-MCO non-HealthChoices counties yet. Although it is not official yet, OHMSAS is moving toward assuming responsibility for behavioral health fee for service from OMAP as a way to resolve issues.

Q: Can providers mix treatment levels in a facility?

A: Yes. Depending on specific provider circumstances.

Q: How are rates in Philadelphia compared among providers?

A: Philadelphia is not like Allegheny County. Rates will be based on provider costs.

Q: Can there be wide differentials in rates across providers?

A: Yes.

Q: Will CCBH and Value be working together for consistency?

A: Providers' service descriptions should provide the consistency among different payors. Rates between Magellan and CBH have been pretty consistent. The experiences of several providers that cross multiple counties will help inform as to experiences and concerns relative to consistency. This process may not be ready for multi-county providers yet.

Q: Is Act 148 going to remain a constant?

A: Richard Gold stated, "I don't know of any county that has lost Act 148 money." In response to a follow-up question, he simply said that no one can guarantee that Act 148 won't be reduced. Money will shift.

Q: Questions about problems with BDAP.

A: Richard Gold responded that BDAP is Estelle Richman's last frontier. The Secretary needs to get the Governor engaged in a discussion with the Secretary of Health to resolve those issues. Pat Valentine (Allegheny County MH) shared that the DOH Director of Licensing may be more of the problem rather than BDAP.

Q: What are the milestones for resolving issues with BDAP?

A: DPW Regional Reps will need to have some conversations with providers to determine the impact on children/youth.

Q: Does PA have a guarantee there will not be problems with CMS as in other states?

A: Since this is the Governor's initiative, Richard Gold offered that those issues were resolved prior to the initiative being announced. The MA Waiver of ten years ago allows the current approach. Meetings have taken place with CMS.

Q: What is the long-range forecast?

A: Marc Cherna (Allegheny County DHS) offered that revenue streams change, but efforts need to address maximizing what is available at the time. Richard Gold offered that there will be additional changes as access to TANF dollars to support child welfare and juvenile justice services decreases.

Q: What is the estimated turn around between billing and payment?

A: Contract requires payment within 45 days of receipt of a "clean" bill. Marc Cherna replied that payment will probably occur more quickly than with the County. Electronic billing is faster than paper billing.

Q: Will the costs of nursing staff, etc. for physical health care be paid for?

A: Physical health care should be paid for now through MA. Staffing costs for PHC will not be covered through this new process.

## **Questions raised in Northeast**

**February 25, 2004**

*Answers provided by Richard Gold*

Opening Comments (Len Pocius)

Act 148 not going away – MA realignment does not mean that C&Y dollars are lost.

Assumptions – fund those services eligible for MA through MA.

Richard Gold is specifically working with residential providers to review services – to see if they can be transferred to MA funding.

Process began in the SE – looking at agencies that counties believed were providing residential services with treatment.

Other providers have been brought in – some are providing services to Philadelphia, Bucks, Delaware, Chester, Montgomery, some only in the NE, some in HealthChoices areas, Some in fee for service areas – different rates, different practices.

Richard Gold – working hand in glove with residential providers – views himself as being at the providers “beck and call” – as an advocate to get the job done.

In the NE there is a new element – there is no history with fee for services counties yet. Collaborative effort with Len Pocius (OCYF) and Michael Orr (OMHSAS) in the NE

Building expertise – not all residential services are transferring; looking at transferring those with treatment parts to MA funding.

Not all programs and not entire programs.

Whether an agency is part of MA – in total or part – is under review and discussion.

No set rules – how much or what is to be transitioned is open for discussion.

Q: Are services being transitioned only for financial reasons?

A: That is part of the rationale but there are also other goals – systems improvement; expertise of the treatment systems is a benefit to children.

The residential services template was developed as a courtesy by Richard Gold to get a sense of what a program description needs to be.

Not all agencies will provide all three levels of care and not all will identify/define treatment levels in the same way.

Medical Assistance realignment – sounds too good to be true? – Richard Gold is working to make it positive – offering support.

If no treatment component in a program, there may be no connection to Medical Assistance realignment; most providers in the group in the room do have some connection to treatment.

Q: Definition of medical necessity?

A: Medical Assistance realignment is forcing the system to look at medical necessity – question remains as to whether it will be applied in a strict way. DPW is developing a 1-2 page document to define medical necessity – levels will vary – definitions may vary – rates will vary. Current definition is viewed as being broad enough to be inclusionary.

Q: Options in addition to RTF acute level of care?

A: Step down levels of care – there will be diverse options created/defined and variations in process.

Q: Lower levels of residential treatment services? Who makes the determination/ decision of levels offered by a provider?

A: Have clinical services been defined within program? The provider raises it. Does county need the services as envisioned by the provider? Is provider known by the county? These factors influence process.

Q: How many programs are accredited? What accreditation is recognized?

A: As of July 1, the state is “taking steps” to accept COA and CARF in the same way that JCAHO is now. Room and Board and treatment will be bundled and paid by MA.

Q: How will children without a diagnosis be served?

A: DPW does not want children to be diagnosed for funding purposes – they will be served as they are now.

Q: Providers who now contract through OMAP/Fee Schedule - takes years to finalize rates – timing? process?

A: Working to expedite this process – depends upon program scope.

Q: Whom will providers be working with?

A: Residential programs should contact Richard Gold; Regional OCYF and OMHSAS offices are also resources.

Q: Education costs?

A: Education is not reimbursable by MA; School districts have been/will be included in discussions, they must pay education costs.

Q: Which regulations/bulletins apply?

A: Chapter 3800's. Program descriptions must comply with MA Bulletins addressing RTFs - JCAHO/Non-JCAHO considerations are addressed in the guidelines – first set on interim guidelines should be followed.

Q: Will there be new rates for services? New rates for counties – R&B?

A: Yes; in some cases, counties will be billed for R&B costs; treatment costs will be billed to MA; new rates may be negotiated; each county will address needs and contracts differently; if service is covered by MA and billed to MA, providers may not need to have a contract with C&Y.

Q: Will providers need to have a rate established with the county C&Y for D&A services?

A: They may not need to – it is to be negotiated. Non-hospital residential services and D&A services are included.

If all services offered are treatment services, the payor will be MA if the agency is accredited. This will be a program by program decision; JCAHO accreditation – likely that the entire program can be billed to MA.

Must certify compliance with RTF interim guidelines.

Providers will get clean copies of applicable bulletins from regional offices.

Q: Rate hikes? Will additional costs be reflected?

A: Medical Assistance realignment is not a vehicle to re-negotiate rates unless a provider is truly offering a higher level of services. Current rates could remain; rates will vary depending upon changes in the service and the negotiations reached related to the revised service description.

Q: Has the program description template been approved by the Department?

A: It is not part of an “approval” process; Providers are encouraged to use it as a guide – not a fill-in-the-blanks document. It was developed as a framework only – suggestions for staffing numbers are not real and not all needs/items will be included in every program developed; Rates will be based on the program descriptions as developed.

General contracting questions -

Each county will develop their own fiscal/budget forms. Some providers will have numerous contracts – it will be a challenge. There will be different rates with different MCO's.

Q: Process to address Title IV-E allowables/non-allowables?

A: Richard Gold will assist providers in sorting this out.

Q: Status of accepting a variety of accreditations?

A: Room and board and treatment may be bundled or may be separate depending upon accreditation status – DPW is moving toward acceptance of three accreditation options.

Q: At federal level, is there sufficient MA funding available to support this expansion?

A: The more done now with Medical Assistance realignment the better position PA will be in if MA is capped at the federal level.

General discussion:

Providers will be contacted by Richard Gold.

Providers are encouraged to look critically at themselves to examine what can be transitioned and changed.

Richard Gold will be working closely with Len Pocius and Mike Orr in the NE.

Will look strategically at who, what and when – it will be an individualized process based on agency services/contacts and experiences.

By July 1 – Medical Assistance realignment gets “switched on” statewide.

There is significant work yet to be done - Counties are now looking to address county C&Y requests for contract information.

Medical Assistance realignment is not only affecting residential services.

Mike Orr and Len Pocius are working on community based and in-home services which may be transitioned.

Areas are being identified that could be moved to MA – it is a two pronged attack.

- Providers of in-home services – counties will identify services that they think can be moved.
- Meet with providers – support MA enrollment – done at a regional level more than the process one-on-one with residential providers.

Next steps –

This was an opportunity to address residential providers' questions/concerns.

Michael Jeffrey – Not looking for one size fits all – the difference between RTFs and residential services is recognized. Why is the current system in place within agencies? Not trying to tell providers that they need to fit a defined mold. Draft program descriptions is not the only format which can be used.

Providers can offer treatment services but not be paid for them by C&Y after July 1 – not an option. Act 148 dollars are not to be used to pay for treatment series.

Fee for service rates – will be negotiated with OMAP/OMHSAS.

HealthChoices – negotiated with the MCOs.

Developmental disabilities services are not part of Medical Assistance realignment.

Group Homes are included.

Assistance to providers will be offered re: billing to OMAP – 48 hour turn around – help with OMAP enrollment and PROMISE process to be offered.

## Questions raised in West

March 15, 2005

Q: What do you expect to be the impact of Medical Assistance realignment on the budget?

A: The State expects that 5% of the total children and youth budget statewide will be switched to MA as a result of the realignment process.

Update of questions regarding federal waiver: Federal waiver unnecessary because the definition of medical necessity is not being changed. There is plenty of room for broad interpretation in the 240 pages of Appendix T.

The concept of RTF was previously limited to one level of care. The expanded definitions will allow for multiple levels of residential care (substitute care). CMS has approved a waiver to pay room and board for agencies which are JACHO, COA and CARF accredited.

Q: How much change will be made in counties' allocations to accommodate Medical Assistance realignment?

A: Counties can expect 5 -10% shift in their allocations as a result of Medical Assistance realignment. Every county will be different.

Q: Questions about use of term "residential."

A: For Medical Assistance realignment purposes, residential means "out-of-biological-home placement" or "substitute care as used in mental health parlance."

Q: Is foster care included?

A: Counties can make that decision.

Q: Is shelter or detention included?

A: Depends on services provided. Shelter programs that provide treatment services to children/youth with DSM IV diagnoses are eligible. Detention that is not county operated could be eligible. Secure residential programs could also be eligible.

Q: What is the time schedule?

A: Counties are to organize teams within the next 3 weeks, to identify programs and services which could be eligible for Medical Assistance realignment. Some of the same issues were discussed last year as part of counties' Integrated Children's Services Plan discussions. OCYF will assist in breaking down necessary barriers in counties.

Q: What about MR programs?

A: They will not be part of Medical Assistance realignment. However, programs that provide MH services to clients with MR are included (license determines category).

Q: Will there be a rate adjustment for MCO's?

A: There will be a one-time rate adjustment on the normal time schedule using one of three reimbursement measures: the traditional actuarial process; reimbursement by actual cost; or, fee for service.

Q: How will MCO's survive when they are or will be incurring costs in advance of a rate increase if they are already overspending?

A: The State will reimburse over expenditures July-January. Financial considerations are in process. After several years experience a second rate adjustment could be considered.

Q: Will this result in a reduction in Child Welfare budget?

A: The State expects there will be some reduction, but not dollar for dollar. Treatment has been supposed to be paid by MA dollars since the 90's. Pennsylvania is late in realigning MA expenditures as 46 or 47 states already do so. If MA gets capped at the Federal level, Pennsylvania will lose out if we don't catch up quickly.

Richard Gold indicated that this process is not about money, but about providing access for children and families to broader services.

Q: Are in-patient D&A services included?

A: The State plan is to be amended to include in-patient, non-hospital D&A services for the under 21 population as in-plan MCO services.

A county staff person expressed concern for the increased number of children/youth who will receive MH diagnoses simply because counties will be forced to do so as they balance fiscal realities. Some counties are adopting assessment instruments (e.g. CANS) to assure adequate gate keeping.

Q: Can a facility have mixed populations in the same physical location?

A: Yes, but services need to be different. MA eligible children/youth must have treatment elements in their programs.

A family advocate expressed concern that children/youth with MH issues should be kept in the MH system.

Q: Who pays when MH "loophole" youth kids commit a crime and are sent to delinquency facilities? Are parents responsible for room and board?

A: Yes. Also, third party liability must be exhausted before MA will pay for treatment services. Must show denial of service.

Q: Will there still be a need for non-MA providers?

A: Yes. The State expects that fewer than 20% of new MA providers will emerge through the realignment process.

Q: What is the bottom line benefit to the State?

A: The expectation is that there will be a \$23-25 million advantage for the State and savings to the counties by increasing the number of children/youth who will be eligible for MA but are not currently eligible for IV-E. Approximately \$75 million will be transferred to the MA budget which is currently about \$2 billion.

Q: MCO's deny costs for physical healthcare now, what happens when behavioral health care costs are denied?

A: The county pays when a child isn't eligible for MA.

Q: Can the county be reimbursed by IV-E and/or Act 148 when MA has been denied?

A: Yes.

Q: Counties have difficulties now with timely physical healthcare enrollment. How will this be improved for behavioral health care?

A: Richard Gold is committed to improving enrollment so there will not be a problem. If providers use the website, court orders are not required. Richard will provide website address. Fee for service counties must have a court order.

Q: Will providers be expected to negotiate with more than one MCO?

A: Providers will be expected to negotiate with the appropriate MA payor for a rate.

Q: Will there be consistency among payers?

A: It is conceivable that providers could be delivering the same treatment services, for different rates, to children/youth from different parts of the State. The State is working to have MCO's agree to pay uniform room and board rates to the same provider. There will be no uniform rates across providers. The payers include: Value, CCBH, CBH, CBHNP, Magellan, and fee for service. A statewide provider could have six different treatment rates, but with only one board rate.

Q: Who pays when court order requires placement beyond approved MA period?

A: County will pay and apply for appropriate reimbursement.

Q: What are some of the lessons learned from what went wrong in Philadelphia?

A: In Philadelphia? Providers got double paid.

Q: Is there a plan to add services to MA fee schedule?      A: No.

Q: Will there be an increase in MH diagnoses?

A: The State estimates that more than 90% of kids who will be eligible already have DSM IV Axis I or II diagnoses.

Q: What are the effects of the Governor Rendell's recommended cuts in MA?

A: Cuts don't apply to children's services.

Q: Another question about Philadelphia experience - What percentage of providers shook out in Philadelphia as MA eligible?      A: 5-10%

Additional questions relative to in-home services:

Q: Who selects the provider to deliver the service?

A: Valerie Vicari responded, "We are hoping that the families will select the provider, with input from C&Y or JPO."

Q: Can providers work in collaboration with other licensed organizations?

A: Yes, with county discussion.

Q: Are all diagnoses covered?

A: All DSM IV diagnoses are covered, except Axis II can't be primary and V codes are not accepted. OMHSAS has approved MST for MA funding, but cautioned counties to not get caught up in the "buzz words" (e.g. FFT, MST, FBMH, family preservation) but rather to look at services provided. Family preservation could be partially eligible.