DRAFT Regional Accountable Entity Policy Guidance on Enhancing Care Coordination for Members admitted to a Psychiatric Residential Treatment Facility or a Qualified Residential Treatment Program

Purpose statement: The purpose of this guidance is to identify the expectations of Regional Accountable Entity (RAE) Care Coordination engagement and participation with and for pediatric Members admitted to residential behavioral health treatment facilities. These expectations will ensure appropriate and timely care is supported by the Member's care team and enhance access to the full spectrum of Medicaid-covered behavioral health treatment services for Members with high-acuity behavioral health needs during and following residential treatment (e.g., Colorado System of Care identification & referrals). (Care Coordinator and RAE Subcontracted Care Coordinator are synonymous for the purposes of this guidance.)

Care Coordination (CC) & Discharge Planning for Members admitted to a Psychiatric Residential Treatment Facility (PRTF) or a Qualified Residential Treatment Program (QRTP)

- **RAE & Provider Collaboration**
    - The RAE should establish an outreach and engagement plan with PRTF and QRTP providers to ensure the RAE & RAE Care Coordinator is involved in Members' full treatment course.
    - RAE involvement and Care Coordination must occur for all members utilizing PRTF & QRTP, regardless of whether HCPF Fee-for-Service (FFS) or the RAE is the payor of the residential benefit.

- **Care Coordination for Members in PRTF and QRTP**
    - Due to the acuity and clinical nature of Members utilizing QRTP & PRTF, it is likely that RAE Tier 3 Care Management will be necessary for at least part of the treatment process. This guidance does not supersede the Care Coordinator's "discretion to move Members in and out of tiers based on clinical assessment of Members, organic referrals from entities serving Members directly, Member requests, and in line with Member needs and preferences, regardless of a Member's diagnosis." (RAE Contract: 8.2.1.3.)
    - "Care Coordinators shall participate in multi-Provider care teams and, as appropriate, multi-agency care teams for Members with cooccurring physical and/or Behavioral Health conditions and/or Members who receive services from various state agencies." (RAE Contract: 8.2.3.1.7.1)
    - Timely and consistent care coordination should occur on at least a monthly basis; this may require scheduling with the QRTP or PRTF provider directly (RAE Contract: 8.3.2.8.)
    - Care Coordinators should request to attend multidisciplinary team and interdisciplinary team meetings (MDTs and IDTs), including while the member is

in QRTP & PRTF; this may also meet the requirement for a monthly CC encounter.

- While the Member is admitted to QRTP or PRTF the Care Coordinator is to conduct the following communication with the residential provider:
  - Request documentation of treatment/care plans:
    - For example, for members in the Tier 3 Care Management, “Contractor shall have policies and procedures to monitor and support whether comprehensive care plans are established within 90 days after Member consents to Care Coordination and updated at least twice a year for as long as the Member remains actively engaged in Tier 3 Care Management.” (RAE Contract: 8.2.3.1.4.1.)
  - Additional requests of QRTP & PRTF providers to support utilization management reviews, discharge planning, etc. may include:
    - Weekly written progress updates with clinical progress or barriers
    - Medication changes
    - Family/caregiver engagement status
    - Discharge planning activities, including a draft discharge plan within 30 days of admission, at the time of any significant status changes, and then a minimum of monthly updates to follow.
    - Request notification of any critical incident within 24 hours with a written report to follow.
    - Request invitation to the care coordinator to participate in any staffings regarding the Member due to significant status changes as well as at least monthly staffings. Likewise, the care coordinator will notify and request that the clinical lead of the Member’s treatment team attend and participate in any staffings, creative solution meetings, elevated solutions meetings, etc. held by the care coordinator/care management.
    - Request updates/changes to the Member’s family engagement status including if engagement becomes impossible or contraindicated.
    - Request a notice of two weeks prior to the planned discharge date from the treatment team and/or any barriers to discharge planning.
- Finally, if a member is awaiting admission into a QRTP or PRTF, including if the member is in a hospital setting, care coordination must occur.
- If the member does not or is unable to consent to CC, the above requests of the provider are still appropriate.

- **Discharge Planning for Members in QRTP & PRTF**
  - Discharge planning is initiated upon admission and includes collaboration with the residential program and the Member and/or the Member’s caregivers, as soon as possible to prepare for successful transition planning. If a county

department of child welfare/human services has an open case with the member, the caseworker should be included in collaborative transition planning.
    - By coordinating care coordination encounters, the Care Coordinator will gain enhanced awareness of ongoing discharge planning and be able to coordinate services for step-down/Colorado System of Care (CO-SOC) referral (RAE Contract: 8.3.6.1.)
    - This level of CC engagement should mitigate potential scenarios where a member is unexpectedly given a discharge notice.
    - If, at discharge, the member is appropriate for CO-SOC, the RAE will make a referral to Enhanced High Fidelity Wraparound (EHFW). EHFW can begin up to 30 days in advance of discharge. The RAE Care Coordinator continues to stay involved through the duration of QRTP/PRTF and CO-SOC for continuity of care. If the member is not appropriate for CO-SOC, the RAE Care Coordinator will assist in referrals for ongoing medically necessary services to support transition from residential treatment.

References:

PRTF & QRTP regulations:
https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=11932&fileName=10%20CCR%202505-10%208.700

Fee for service QRTP Billing manual:
https://hcpf.colorado.gov/qrtf-manual

Fee for service PRTF Billing manual:
https://hcpf.colorado.gov/ptrf-manual

Fee for service Operational memo- Utilization Management and Assessment Requirements for Qualified Residential Treatment Providers (QRTP) and Psychiatric Residential Treatment Facilities (PRTF):
https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20OM%2025-032%20Utilization%20Management%20and%20Assessment%20Requirements%20for%20Qualified%20Residential%20Treatment%20Providers%20%28QRTP%29%20and%20Psychiatric%20Residential%20Treatment%20Facilities%20%28PRTF%29.pdf

Colorado Statewide Standardized UM (SSUM) Guidelines:
chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20Statewide%20Standardized%20UM%20%28SSUM%29%20Guidelines%20Draft%20Feb%202023.pdf