Residential Treatment for Child Welfare Youth: Legislative Request for Information

Fiscal Year 2025-26 Response to a Request from the Colorado General Assembly Joint Budget Committee

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Submitted to: Joint Budget Committee

COLORADO
Department of Health Care Policy & Financing

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Introduction

In accordance with Colorado Senate Bill 25-294, the Department of Health Care Policy and Financing (HCPF) has begun meeting with counties, providers, Regional Accountable Entities (RAEs), Behavioral Health Administration (BHA), and Colorado Department of Human Services (CDHS) to review the process and impact of moving the utilization management and payment of children in the custody of county child welfare from HCPF's fee-for-service (FFS) payment structure to the behavioral health (BH) capitation administered by RAEs on behalf of HCPF. There have been thus far two half-day meetings and several additional meetings scheduled with the aforementioned parties over the coming months.

HCPF submits this report in response to a request for information from the Joint Budget Committee regarding the transition of residential treatment for child welfare youth to the behavioral health capitation. Given the quick turnaround of this legislative request for information (LRFI), much data in this response is preliminary and needs further time to be verified for complete accuracy or the data is not information HCPF regularly pulls and therefore not readily available within the timeframe of this LRFI. HCPF will provide the requested data no later than August 1, 2025.

Psychiatric Residential Treatment Facility

A Psychiatric Residential Treatment Facility (PRTF) is an inpatient psychiatric facility for children and youth who need intensive psychiatric care but do not require the level of care of an inpatient hospital setting. PRTF services are for Health First Colorado (Colorado's Medicaid Program) members under the age of 21 who need inpatient services to treat a psychiatric condition under the direction of a physician.

Qualified Residential Treatment Program

Qualified Residential Treatment Programs (QRTP) is a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances. As appropriate, QRTP treatment facilitates the participation of family members in the child's treatment program, including siblings, and documents outreach to those family members.

Utilization and Length of Service for Youth Residential Treatment

HCPF has identified the following metrics indicating the level of utilization of youth residential treatment.

- Total number of child welfare and non-child welfare youth in QRTP and PRTF placements in the prior fiscal year:
    - Child Welfare: Based on preliminary data, for children and youth in custody of child welfare, 96 were in a PRTF and 137 were in a QRTP for State Fiscal Year (SFY) 2023-24.

    - Non-Child Welfare in Behavioral Health Capitation: Based on preliminary data, for children and youth in the BH capitation, 193 were in a PRTF and 50 were in a QRTP for SFY2023-24.

- Average length of stay for child welfare and non-child welfare youth in QRTP and PRTF placements in the prior fiscal year:
    - Child Welfare: Based on preliminary data, for children and youth in custody of child welfare, the average length of stay within the SFY2023-24 was approximately 139 days for PRTF and 105 days for QRTP.
    - Non-Child Welfare in Behavioral Health Capitation: Based on preliminary data, for children and youth in the BH capitation, the average length of stay within the SFY2023-24 was approximately 101 for PRTF and 95 for QRTP.
- Number of youth who were determined to not meet medical necessity, but no step-down service was available in the prior fiscal year:
    - For SFY2023-24, RAEs reported 25 youth were determined to not meet medical necessity for admission or continuation of residential services but no step-down services were accessed. It should be noted that many of these children are subsequently placed in a residential facility if there is a lack of the appropriate community treatment options.
- Number of youth who re-entered the hospital or emergency services within 3 months of discharge from a QRTP or PRTF in the prior fiscal year:
    - This data is not information HCPF regularly pulls and is not readily available within the timeframe of this LRFI. HCPF is pulling and analyzing this data and will submit it by August 1, 2025.

Step-down services available across the state

Colorado has a number of supportive and step-down services available to Medicaid and CHP+ child and youth members. All children and youth who are enrolled in Medicaid are able to receive care coordination services from RAEs as part of their care. Step-down services are community based treatment services available to the child upon discharge. These services include outpatient therapy, intensive community-based treatment, intensive outpatient treatment (IOP), day treatment, partial hospitalization programs (PHP), and psychiatric medication services.

HCPF is working with the Behavioral Health Administration (BHA) and RAEs to build a system of care for children and youth enrolled in Medicaid. Starting in SFY2025-26, the services provided in the Colorado System of Care (CO-SOC) will be available to all children and youth enrolled in Medicaid who are stepping down from QRTP or PRTF to a family setting. HCPF, RAEs, and BHA will be working with Colorado State University and University of Colorado (Kempe Center) to increase the number of providers available to provide the following intervention within the CO-SOC framework: assessments, high-fidelity wraparound, and intensive in-home treatment such as Multisystemic Therapy and Functional Family Therapy.

Medical Necessity Determination for Youth Residential Treatment

"Medical Necessity" is defined in 10 CCR 2505-10 section 8.076.1.8 as a good or service that, consistent with 42 U.S.C. § 1396d(r)(5):

1. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. For members under 21, per section 8.280.4E, this includes a reasonable expectation that the service will assist the member to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living.
2. Is provided in accordance with generally accepted professional standards for health care in the United States.
3. Is clinically appropriate in terms of type, frequency, extent, site, and duration;
4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker, or provider.
5. Is delivered in the most appropriate setting(s) required by the member's condition;
6. Is not experimental or investigational; and
7. Is not more costly than other equally effective treatment options.

Furthermore, HCPF and the Colorado Department of Human Services (CDHS) have worked with counties and providers to develop guidelines on how to apply the medical necessity definition to PRTF and QRTP specifically. As a result, the "Colorado Statewide Standardized Utilization Management (SSUM) Guidelines for Youth Under 21 Years Old" is used in the application of determining medical necessity for these services. The intensity of the service must meet the needs of the child in the least restrictive environment possible. Included in these standards, the services must be:

- Proper and needed for the treatment of the child;
- Provided for the direct care and treatment of the child; and
- Meet the standards of good medical practice in the local area and are not mainly for the convenience of any agency or provider.

Colorado also must abide by federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards. EPSDT can only be applied if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the Medicaid statute at 42 U.S.C. § 1396d(a). For example, "maintenance" and "rehabilitative services" are covered by EPSDT, even if the particular maintenance or rehabilitative service requested is not listed in Health First Colorado clinical policies or service definitions.

2. The service must be medically necessary to prevent, diagnose, evaluate, correct, ameliorate, or treat a defect, physical or mental illness, or a condition diagnosed by the member's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to prevent, diagnose, evaluate, correct, ameliorate, or treat a defect, physical or mental illness, EPSDT also requires payment of services that are medically necessary to sustain, maintain or support, rather than improve, cure or eliminate health problems, to the extent that the service is needed to prevent, diagnose, evaluate, correct, ameliorate, or treat a defect, physical or mental illness, or condition.
3. The requested service must be determined to be medical or behavioral health in nature.
4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.
8. Health First Colorado may cover services in the most cost-effective mode so long as the less expensive service is equally effective and actually available. Health First Colorado may not deny medically necessary treatment to a member based on cost alone but may consider the relative cost effectiveness of alternatives as part of the prior authorization process.

RAEs must navigate barriers to finding placement for the child or youth. If continued stay at a QRTP or PRTF is determined to no longer be medically necessary, the RAE is still responsible for ensuring services are provided at the point of step-down. If there are not identified appropriate services for the child or youth the RAE must identify and pay for the alternative services, which may include a continued stay at the current treatment facility. RAE contracts specifically state the RAE "Identifies alternate services and/or level of care that are recommended instead of the requested service when the original request is denied for lack of Medical Necessity."

If medical necessity is approved, the length of stay will vary based on the needs of the child or youth. If medical necessity is not found for a QRTP or PRTF level of care, RAE contract section 4.3.3 states that the RAE must pay for up to 10 days from the date the Adverse Benefit Determination is communicated for a termination or suspension of approved services. If the decision is appealed, the RAE will continue to pay the previously authorized time period for services while a resolution is determined. After the ten days from the Adverse Benefit Determination communication, the RAE can not pay for QRTP or PRTF service days if the RAE has identified available treatment services post discharge. If the appropriate services are available but the family will not allow the child to return home or the county does not have a living arrangement for the child, the RAE can only pay for the QRTP or PRTF if medical necessity for that level of care is met.

Collaboration with QRTP and PRTF providers, hospitals, county departments of human services, and families is critical to HCPF's efforts to establish and refine effective medical

necessity procedures. In Spring 2025, HCPF worked with counties to have two half day sessions to review the process for reviewing medical necessity determinations when placing a child in a residential setting. The work is continuing with meetings scheduled in a standing meeting with HCPF, CDHS, BHA, RAEs, and counties, and will include providers.

In addition, the aforementioned SSUM guidelines were created through extensive stakeholder involvement. HCPF included stakeholders in the process of creating those guidelines, which are instrumental in the process of determining medical necessity.

As it relates to the assessment tool being developed that will inform the level and types of care a child or youth needs, HCPF has worked with QRTP and PRTF providers, counties, CDHS, BHA, and other stakeholders in developing the next iteration of that tool. This tool will provide the key clinical information needed in determining medical necessity.

Continuum of Care

Starting in SFY2025-26, to seamlessly connect eligible Medicaid enrolled children and youth discharging from QRTP and PRTF settings with CO-SOC services, RAEs will have a process to have RAE care managers participation in discharge planning. At a minimum, RAE care coordination supports and services, which may include High Fidelity Wraparound care coordination, should begin with the members and families at least 30 days prior to the member's proposed discharge date to facilitate a smooth transition to community-based services and supports. By having a High-Fidelity Wraparound coordinator working with the provider, RAE and family members, there will be better communication and coordination for the child transitioning into community based services.

It is the standard practice for discharge/transition planning to include vested parties relevant to the care of the child, this includes the discharging provider, families, counties, care coordinators and other providers if they already have a working relationship with the child or youth. In addition to existing rules outlining these expectations, as part of HCPF's work in building a system of care, contractual expectations will include High Fidelity Wraparound coordinators to assist in the planning and transition of a young person from residential to their community prior to discharge.

For QRTP rule, the following requirements are outlined in 12 CCR 2509-8 7.705.200 "Requirements of a Qualified Residential Treatment Program":

"7.705.207.C The family engagement and permanency team shall be included in the development of the individual child and family plan."

"7.705.208.A Within forty five (45) calendar days of admitting a child/youth into care, the program must develop a discharge and aftercare plan, in collaboration with the county department of human/social services or placing entity, the child/youth, and the family engagement and permanency team."

"7.705.208.D The plan must be reviewed and/or modified no less than monthly during the child's/youth's placement and during aftercare services. Changes to the plan must be documented."

In addition, RAEs are responsible for care coordination for all Medicaid members, even if they are not paying for the QRTP or PRTF Treatment. Under the new Colorado System of Care (CO-SOC) structure, the RAE will assign a High Fidelity Wraparound coordinator to work with the QRTPs and PRTFs for discharge planning.

Implementation Plan and Anticipated Financing Structure

To comply with federal requirements, the ACC Phase 2 contracts, effective from 2018 to June 30, 2025, include requirements for timely payment of clean claims. According to the contract, RAEs must pay 90% of clean claims within 30 days of receipt and 99% of clean claims within 90 days of receipt. In ACC Phase 3, effective July 1, 2025, HCPF will strengthen clean claims payment standards. RAEs will be required to pay 90% of clean claims within 20 days of receipt and 99% of clean claims within 45 days of receipt. In practice, RAEs typically pay more than 90% of clean claims within 14 days of receipt or even sooner.

In all cases, claims must be medically necessary, and prior authorizations are required for certain services.

HCPF utilizes several contractual requirements to improve RAE connection with providers, counties, and families and ensure access to benefits. RAEs are contractually required to have electronic and written communications to inform members of the services the RAE can provide members and information about a member's Medicaid benefits. Information regarding a member's assigned RAE is included on the Medicaid identification card that is available electronically.

RAEs also have a variety of requirements around educating and partnering with their contracted providers. For instance, RAEs are required to distribute information and provide technical assistance to help providers understand all available Medicaid benefits and how to access them. This includes educating providers about RAEs' and HCPF's responsibilities and supports regarding the federal requirements for Early and Periodic Screening, Diagnostic, and Treatment for children and youth. RAEs are also required to ensure providers have access to trainings that address Medicaid benefits and EPSDT, including connecting providers with available state and HCPF trainings and making available trainings that address Medicaid benefits and EPSDT at least once every six months.

Lastly, RAEs are contractually required to promote members' physical, behavioral, and social well-being by creating a diverse network of health care providers and community organizations that provide services to residents within RAE's geographic region. RAEs must establish documented policies and procedures to facilitate effective collaboration, communication, and coordination with state and county agencies and programs, providers, health plans, and community organizations serving shared Members. Specific to county child welfare agencies, RAEs must collaborate with them to improve the timely notification of children and youth members involved in the child welfare system who require care coordination support, including but not limited to Members in foster care and those who have recently (within one year) emancipated from foster care.

HCPF has several efforts underway to increase sustainability of long-term funding for child welfare youth in need of residential treatment.

1. Effective January 2025, HCPF added social emotional disturbance (SED) as a disability to be included in the Child Habilitative Residential Program (CHRP), which will hopefully reduce the number of children requiring child welfare involvement for access to Medicaid services.
2. HCPF, in partnership with BHA, CDHS, and stakeholder committees, to develop a Colorado System of Care that will offer more intensive in-home services as a step-down from residential treatment. Starting SFY2025/26 there will be efforts to increase access to these services for children discharging from residential settings.
3. HCPF has contracted for an actuarial analysis of PRTF rates as required by HB24-1038. This analysis will be complete by June 30, 2025.
4. For children under 13, HCPF created QRTP rates to address the cost of a facility serving these children within a facility that is specific to this age group. We have two providers interested and are working to finalize an agreement with them.
5. HCPF also obtained an agreement with the Centers for Medicare and Medicaid Services (CMS) to negotiate in-state and out-of state rates for members who are able to access medically necessary services under the EPSDT program. This allows HCPF to have flexibility to serve youth who are in need of residential care.