Virginia Department of Behavioral Health & Developmental Services

Report on HB 728/SB 734

Children's Residential Workgroup Report

To the Chairs of the Senate Finance Committee, House Appropriations Committee, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Thursday, January 21, 2021

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Table of Contents

Executive Summary

Last year, approximately 2,700 youth accessed residential treatment in Virginia, including roughly 1,900 Medicaid members.[1] Psychiatric residential facilities provide structured, intensive treatment, at times as a step down from acute psychiatric hospitalization, focusing on family and individual therapies, crisis prevention, and the development of psychosocial supports to decrease repeat hospitalizations and future out-of-home placements. Placement in residential treatment facilities may be recommended for youth who have repeated acute psychiatric hospitalizations and have not been able to benefit from less restrictive levels of care. Best practice for use of residential treatment requires that the youth meet medical necessity criteria and that less restrictive, community-based options have been explored prior to placement.

The process for approval of and placement in residential treatment for youth in Virginia is fragmented, time-consuming, confusing, and inefficient. The Children's Residential Workgroup (HB 728/SB 734) convened between September and November this year to review the current process for approval and placement; identify barriers to timely placement; and develop recommendations for improving and expediting the process.

The principal barriers to timely placement into residential treatment for children and adolescents included:

1. A lack of a collective understanding of the approval and placement process – including the Independent Assessment, Certification, and Coordination Team (IACCT) and the Family Assessment and Planning Team (FAPT) processes – and the roles of different stakeholders in the process;
2. The time-consuming nature of the authorization and admissions process, which consists of medical necessity determination as well as engagement of local FAPTs and a determination that all possible alternative services have been explored; and
3. Challenges identifying a willing and appropriate residential provider with availability once it has been determined that a youth's symptoms and needs meet medical necessity criteria and FAPT has been engaged and approved the educational costs.

In order to improve and streamline the process for Virginia's families, the workgroup developed seven, core recommendations:

1. Improve the alignment of the IACCT and FAPT processes to ensure efficient, timely, and better coordinated access to residential treatment.

2. Improve information sharing across the system of care to ensure timely, relevant, and necessary information about the individual and family seeking residential treatment is exchanged by involved stakeholders.

3. Standardize the training and education materials for individuals, families, and other stakeholders to provide comprehensive and uniform information about the referral and admissions process to children's residential placements.

[1] Data from the Office of Children's Services, FY2019 and from Magellan BHSA, CY2019. Numbers include group home and psychiatric residential treatment.

4. Standardize the admissions referral material through a universal application process to decrease the administrative burden on individuals, families, referring agencies, and treatment providers who are seeking timely admission to children's residential treatment.
5. Continue to build out the comprehensive continuum of care for the behavioral health system to increase access to, and availability of, alternatives to residential and inpatient treatment.
6. Increase the availability of residential treatment facilities (including those that specialize in evidence-based treatment for specific disorders or complex needs) so that individuals and families have an informed choice of the right provider to meet their needs.
7. Increase the use of family support partners and peer navigators to provide support and improve timeliness in accessing services.

The workgroup stressed the importance of continued investment in developing a comprehensive continuum of trauma-informed, evidence-based behavioral health services for children and adolescents, which would include less restrictive community-based alternatives to residential treatment. Case management and care coordination also must be sufficiently resourced to support families in navigating the service delivery system and accessing appropriate interventions. The workgroup agreed that out-of-home placements should be avoided whenever possible. Nevertheless, when placement in a children's residential facility is the treatment modality that best meets the individual's needs, the current process needs reform to ease the burden on Virginia's families, and the Commonwealth needs additional facilities to treat more challenging and specialized cases here in Virginia.

Preface

House Bill 728 and Senate Bill 734 of the 2020 Acts of Assembly directs the Secretaries of Education and Health and Human Resources to establish a workgroup to study the approval process for children's residential psychiatric placement. The language states:

> *That the Secretaries of Education and Health and Human Resources shall establish a work group to consist of the Commissioner of Behavioral Health and Developmental Services, the Superintendent of Public Education, the Director of Medical Assistance Services, the Commissioner of Social Services, and the Director of the Office of Children's Services, or their designees, and representatives of hospitals providing services to children and adolescents, providers of residential psychiatric services for children and adolescents, community services boards, and behavioral health advocacy groups to (i) review the current process for approval of residential psychiatric placements and barriers to timely approval of residential psychiatric services for adolescents and children, (ii) develop recommendations for improving such process and ensuring timely approval of residential psychiatric placements and services for adolescents and children, and (iii) develop recommendations for a process to expedite approval of requests for residential psychiatric placements and services for adolescents and children who are receiving acute inpatient psychiatric services. The Commissioner of Behavioral Health and Developmental Services and the Director of Medical Assistance Services shall serve as co-chairs of the work group. The work group shall report its findings and recommendations to the Chairmen of the House Committee on Appropriations, the Senate Committee on Finance and Appropriations, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2020.*

Introduction

Children's residential facilities are defined in 2VAC35-46-10 as a "facility, other than a private family home, where 24-hour per day care is provided to children separated from their legal guardians and is required to be licensed or certified by the Code of Virginia" This definition excludes facilities licensed by the Department of Social Services (DSS) as child-caring institutions as well as acute-care private psychiatric hospitals. Residential treatment constitutes intensive treatment, "one step down" from acute inpatient psychiatric care, which takes a child or adolescent out of his or her home and community in order to bring them to a concentration of professional services provided at high intensity. As an intensive, and expensive, out-of-home option, placement in a residential facility is contingent on the youth meeting medical necessity criteria and ensuring that all less restrictive, community-based options have been explored prior to placement.

For Virginia's youth with Medicaid (or for those who are privately insured and become Medicaid eligible after 30 days in residential treatment), the medical necessity determination process, managed by Magellan of Virginia, a contractor of the Department of Medical Assistance Services (DMAS), is known as the Independent Assessment, Certification and Coordination Team (IACCT) process. Residential facilities are required to provide all necessary services, including educational services in addition to psychiatric care, and all non-Medicaid covered expenses are typically funded through local Children's Services Act (CSA) programs, with eligibility being determined by CSA Family Assessment and Planning Teams (FAPTs). Unlike other Medicaid-funded services, local governments share the state's match to federal Medicaid funding through the CSA process. The locality share of funds is deducted from state reimbursement for CSA expenditures. As a result, CSA decisions about and funding of treatment services in residential settings is a partnership between state and local government.

The process for approval of and placement in residential treatment for Virginia's youth is fragmented, time-consuming, confusing, and inefficient. Families are required to go through multiple processes which braid together multiple funding sources, only adding to the frustration and psychosocial disruption that is often the impetus for seeking a higher level of care. Regardless of the source of the referral for residential treatment, the process for determining eligibility is the same, including for those youth who are already in an acute psychiatric inpatient setting. It is important to note that while residential treatment is a high level of care, unlike acute psychiatric inpatient, it is a non-emergent treatment setting. The decision to initiate the process for placing a youth in residential treatment is not an easy one. There is a balance between the urgency of placement of a youth who has experienced repeated hospitalization needing a stable environment with recognizing that the length of stay may be anywhere from three to eight months on average, removing the youth from the familiar supports of their home and community.[2]

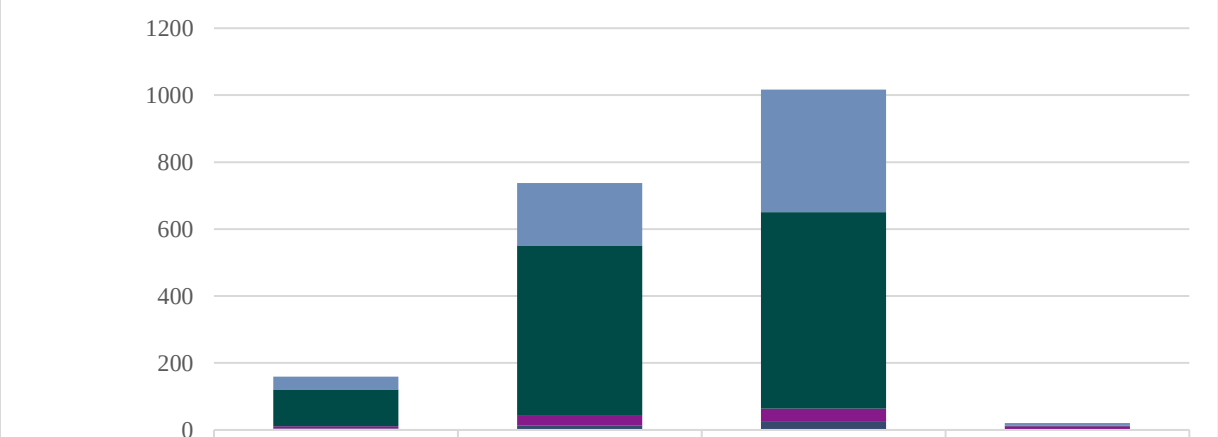
[2] Average length of stay in FY2019 for Medicaid members was 116 days in a therapeutic group home, 180 days in a psychiatric residential treatment facility, 172 for EPSDT therapeutic group home placements, and 218 for EPSDT psychiatric residential treatment facility placements.

Background

Youth in Residential Treatment

Virginia Medicaid contracts with Magellan of Virginia to serve as the Behavioral Health Services Administrator for children's residential treatment services. Nearly all youth in DSS custody are also covered by Virginia Medicaid. Magellan is also required based on medical necessity criteria to cover services that fall under the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, which allows for additional services for youth as a covered benefit. EPSDT residential treatment facilities in Virginia primarily serve youth with intellectual or developmental disabilities. Review of the Medicaid data from calendar year 2019 showed that there were 1,935 Medicaid youth admitted to residential treatment – 131 of these were funded by under EPSDT. Of these youth, 49 percent were female, and 51 percent were male. Over a quarter (26.7 percent) were in foster care at the time of admission. The average length of stay for youth in a residential facility funded by Medicaid was between 116 and 218 days. Often these youth have complex comorbidities including intellectual or developmental disabilities. Figure 1 shows calendar year 2019 Medicaid and EPSDT residential admissions by age group, and Figure 2 shows admissions by race or ethnicity. It is important to note that race and ethnicity categories are voluntary fields within the Medicaid application.

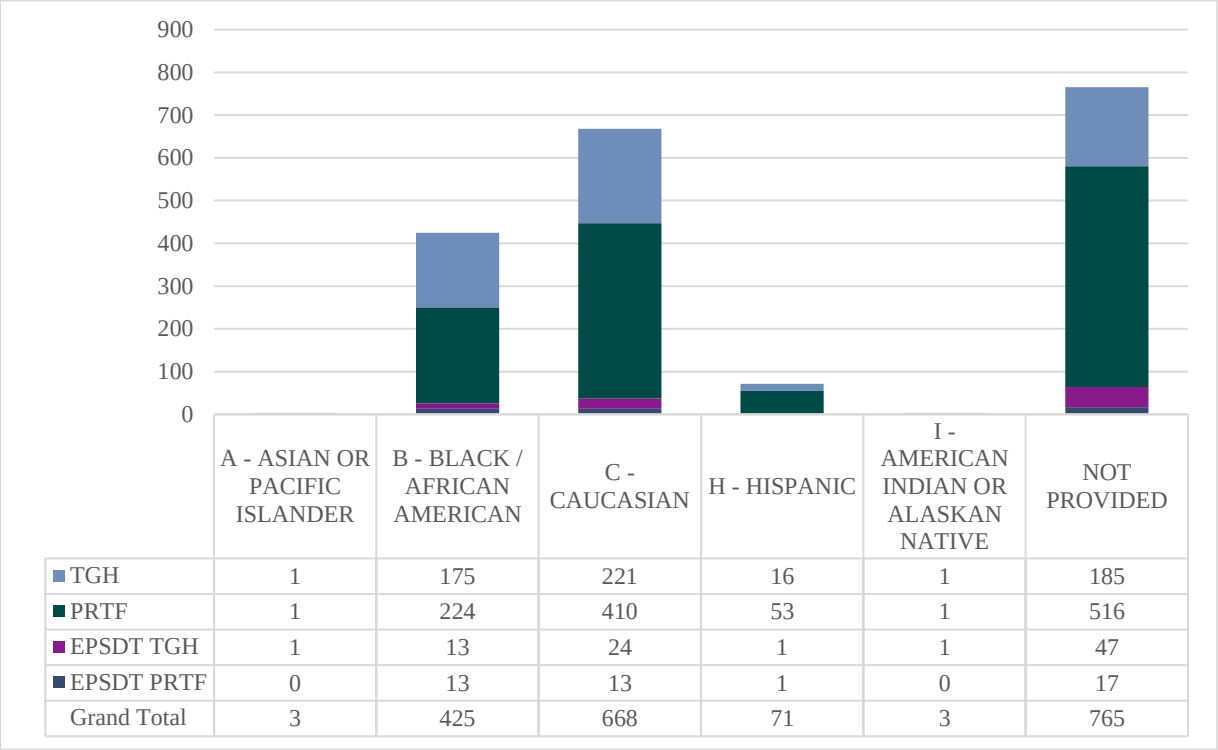
Figure 1: 2019 Medicaid Children's Residential Admissions by Age Group[3]



	5-10	11-14	15-17	18-20
TGH	38	187	366	8
PRTF	110	506	587	2
EPSDT TGH	7	31	38	11
EPSDT PRTF	4	14	26	0
Grand Total	159	738	1017	21

[3] TGH refers to therapeutic group homes and PRTF refers to psychiatric residential treatment facilities

Figure 2: 2019 Medicaid Children's Residential Admissions by Race or Ethnicity



	A - ASIAN OR PACIFIC ISLANDER	B - BLACK / AFRICAN AMERICAN	C - CAUCASIAN	H - HISPANIC	I - AMERICAN INDIAN OR ALASKAN NATIVE	NOT PROVIDED
TGH	1	175	221	16	1	185
PRTF	1	224	410	53	1	516
EPSDT TGH	1	13	24	1	1	47
EPSDT PRTF	0	13	13	1	0	17
Grand Total	3	425	668	71	3	765

The Approval and Placement Process for Children's Psychiatric Residential Treatment

CSA Process (FAPT)

Determination of CSA eligibility is made by local FAPTs. There are 130 locally administered CSAs. There are no statewide standards for the timelines, policies, and procedures of each local program, other than those established in the Code of Virginia or policies of the State Executive Council. The size and resources of the locality impact the local CSA program and its approach to completing its review of requests for residential services.

The educational component of residential treatment is not covered by Medicaid. Therefore, CSA funding is used for the required educational services for youth in residential care and is a primary funder for the first month of treatment services for youth who are not Medicaid eligible at the time of admission. For youth who are already engaged with their local system of care, the family and case manager may refer to the IACCT process. When youth are unknown to their local CSA program, the appropriate CSAs are notified whenever an IACCT process begins. With parental consent, a case manager from a local agency is assigned and a FAPT meeting is scheduled to both determine CSA eligibility and develop service recommendations. From there, the local Community Policy and Management Team must authorize the recommended services.

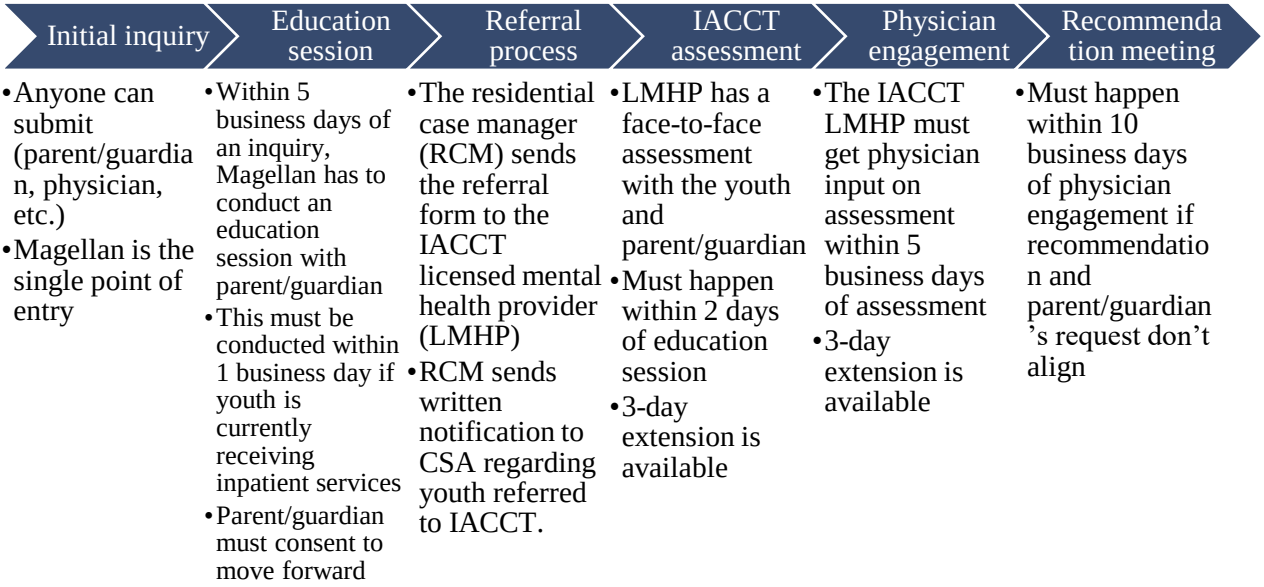
After the FAPT recommends a residential placement, the local case manager and other CSA team members work to identify a provider. Each CSA individually contracts with various residential providers and works with the youth, family, and providers to find an appropriate

placement. Knowledge of local resources as well as connections to local schools and other agencies allows the FAPT to support families in accessing necessary supports for discharge planning.

IACCT Process for youth with Medicaid

The IACCT process was implemented in 2017 to meet CMS requirements regarding the authorization for medical necessity. All inquiries for Medicaid-funded children's residential admissions go through Magellan of Virginia. The IACCT is intended to support a youth- and family-focused system that will match future managed care administration structures and efficiently yield better outcomes by thorough care coordination, involvement of youth and families in all aspects of care, and promoting community engagement, individualized residential treatment needs, comprehensive discharge planning, and more. In cases where the youth is receiving Medicaid-funded residential treatment, the IACCT licensed mental health professional (LMHP) will conduct a reassessment at 90 days or earlier. The reassessment must be completed face-to-face or via asynchronous telemedicine. An audio-only assessment with the youth and a simultaneous face-to-face assessment with the legal guardian are only an option if distance is a barrier. An overall timeline of the IACCT is available in Figure 3.

Figure 3: Overview of the IACCT Process Timeline



IACCT Process Special Considerations

The IACCT process includes specific considerations for youth in time-sensitive circumstances: 1) youth in foster care who are placed in a children's residential facility that need emergency placement; 2) youth who are newly eligible for Medicaid; and 3) youth who are currently in an acute inpatient psychiatric facility and cannot safely return to the community to await residential placement.

Youth in foster care

Youth in foster care may be placed in residential facilities according to the DSS Emergency Placement definition. The inquiry should be submitted within five days of the member being placed or five days of the member becoming eligible for Medicaid. The inquiry can be submitted

by anyone. In this situation, the certificate of need (CON) for residential placement is completed by the treatment team at the residential facility, which some residential clinicians worry may generate conflict of interest concerns. Other aspects of the IACCT process remain the same.

Youth who are newly eligible for Medicaid

Youth may already be in a residential placement under alternative funding or commercial insurance and become Medicaid eligible after placement. When this occurs, inquiry to seek Medicaid reimbursement for the residential stay should be submitted within five days of the member becoming eligible for Medicaid. The CON is completed by the treatment team at the residential placement. Other aspects of the IACCT process remain the same.

Youth who are currently in an acute inpatient psychiatric facility

For children and adolescents in inpatient facilities, the residential inquiry should be submitted to Magellan within one business day of determining that residential treatment services will be an aspect of the youth's discharge plan. If the youth cannot safely be maintained in the community while waiting for residential placement, the treatment team at the inpatient facility will complete the CON, and the youth may be placed in a residential facility directly from the acute inpatient setting prior to the IACCT process being completed. The youth would still need to be considered by the FAPT for educational costs as CSA funds may not be obligated without approval form the local CSA program. Other aspects of the IACCT process would remain the same. If the treatment team determines that the youth can be safely maintained in the community while waiting for a placement, the youth may be discharged from the acute setting and pursue the typical IACCT process.

Youth who are Privately Insured

Youth who are privately insured are not required to utilize the IACCT process to access residential psychiatric treatment. Commercial insurers offer varied access and degree of coverage for residential treatment services, and therefore youth who are privately insured will experience varied access or degree of coverage. Most youth with private insurance that require residential treatment will also require funding from the local CSA for coverage of required educational costs. They may also require Medicaid coverage for medical costs in the event that the insurer’s medical necessity criteria are no longer met but the treating facility continues to identify a clinical or psychosocial need for a continued stay.

The Importance of a Comprehensive Continuum of Behavioral Health Services

Improving and expediting the process of approval and placement in a children’s residential facility is critical to getting youth to the appropriate level of care in a timely manner and minimizing the burden on Virginia’s families. Nevertheless, residential treatment is only one component of a comprehensive system of care and should be used only when other community-based services have been unsuccessful or when a child’s immediate needs cannot be safely served by a community-based alternative. A more seamless and comprehensive system of care across the Commonwealth without geographic, financial, or administrative barriers is necessary for families to access the appropriate level of service at the right time. The complete implementation of System Transformation Excellence and Performance (STEP-VA), which provides essential core service types, will support the necessary enhancements and

transformation of the public community behavioral health system which is administered by the 39 community services boards (CSBs) and one behavioral health authority across the Commonwealth. In conjunction with STEP-VA, the Medicaid Behavioral Health Enhancement (BHE) illustrates a model for a continuum of behavioral health services for all individuals with Medicaid (see Appendix B). [4] Implementation of these two critical initiatives work to address both the development of services and the long-term financial sustainability of those services.

Workgroup Charge and Outcomes

The Children's Residential Workgroup began meeting in September to review and discuss proposed changes to the approval and placement process for children and adolescents in residential psychiatric placements. Specifically, the workgroup was charged with:

1. Reviewing the process for approval of residential psychiatric placements;
2. Identifying any barriers to timely approval of placements;
3. Recommending improvements to the process to ensure timely approval of placements; and
4. Recommending processes for expediting approval of placements for children and adolescents receiving inpatient services.

The workgroup consisted of stakeholders from across Virginia's child-serving system, including CSBs, providers of residential psychiatric services, local CSAs, and acute care hospitals. Mental health advocates, family support partners and family representation as well as Medicaid Managed Care Organizations (MCOs) and BHSA were also engaged in the workgroup. The state agencies represented included DMAS, OCS, DSS, the Department of Juvenile Justice (DJJ), the Department of Education (DOE), and the Department of Behavioral Health and Developmental Services (DBHDS). Appendix A lists all workgroup members.

The workgroup began its work by reviewing the process for residential treatment approval and placement. Workgroup members then identified various barriers to timely approval and placement from their unique perspectives. The full workgroup then spilt into three subgroups to examine the particular barriers and possible solutions in each of the following three areas:

1. The IACCT process;
2. The FAPT process; and
3. The process of identifying an available placement.

Key barriers and proposed solutions were brought to the larger workgroup and discussed. The following section details the overarching barriers identified as well as immediate and long-term recommendations.

Key Barriers to Timely Approval and Placement

<u>Need for alternatives to residential treatment</u>

[4] Virginia Department of Medical Assistance Services, Virginia Department of Behavioral Health and Developmental Services, & the Farley Health Policy Center. Virginia Medicaid Continuum of Behavioral Health Services. December 2018.

While the focus of the group was specifically on identifying ways to expedite the approval process for children's residential placement, the group noted that residential placement could be avoided in some instances if families could access case management, more community-based services, and earlier intervention with trauma-informed, evidence-based treatments. The work being done through STEP-VA and BHE – in particular, mobile crisis, partial hospitalization, intensive outpatient, and intensive care coordination using high fidelity wraparound services – will help to build the continuum of services in Virginia and, over time, lead to increased utilization of appropriate community-based intervention and lower utilization of higher levels, specifically residential treatment, and inpatient hospitalization.

Collective understanding of the process

Throughout the workgroup, it was clear that there was a lack of shared understanding about the critical details related to the approval and placement process for residential programs for children and adolescents. There is a clear need for defined roles for each of the different entities in the system, including private insurance plans, DMAS and Magellan, local CSAs and FAPTs, residential providers, and the CSBs. Understanding these roles is critical to developing a comprehensive picture of the entire process, which is necessary both for families to be able to access services and for providers to help guide youth through the process and make appropriate referrals. A collective understanding of the process – and the various roles within the process – is necessary to identifying and eliminating inefficiencies and risking inappropriate referrals to this restrictive level of care.

Timeliness of the approval process

The workgroup agreed that having dual processes for residential approval with IACCT and FAPT can lead to placement delays ranging from a couple of weeks to months. The first piece of the process is the determination of medical necessity. For Medicaid members, this determination is made through the IACCT process, which has defined timelines both for youth referred outside of the inpatient setting and youth being referred from an inpatient setting. Nevertheless, the IACCT timelines are sometimes seen as burdensome to the family and do not align with the timeline of an inpatient acute hospitalization (average of five to eight days). Furthermore, there are times when the determination of IACCT and the determination of the local FAPT do not align as the local FAPT may determine that the youth can be served in a community-based setting. The different determinations between the two processes, using different criteria and practice frameworks, can cause frustration for families and impede the process of securing timely services. Furthermore, FAPT review and approval is necessary to securing funding for the educational portion of residential treatment (and the entire cost of placement for certain youth). This timeline and criteria can vary by locality. Finally, for both the IACCT and FAPT processes to run smoothly, both teams need to coordinate and share information in a timely manner, something that does not consistently occur, often due to confidentiality requirements and needing legal guardians' consent prior to exchanging information.

Identifying Available and Appropriate Placements

The final significant delay for youth referred to residential treatment is identifying an available and appropriate provider. It was noted by a local CSA that in-state residential placement can occur within three days to one week if the child is known to CSA. However, if the child is not known to CSA, the residential placement process can take up to six weeks due to the need to collect significant information to make referrals to residential providers. Due to local variation in

the number of youths needing residential treatment, a larger CSA will likely have more contracts in place due to placing more frequently than a smaller CSA. With COVID-19, transportation has become a new barrier that is sometimes extending the timeline from referral to placement.

The Office of Children's Services sponsors a web-based Service Fee Directory with provider listings. However, there is not currently a comprehensive source of information about bed availability, including different types of residential settings (i.e., psychiatric residential treatment facilities and therapeutic group homes) as well as residential facilities with particular specialties, including treating youth with intellectual or developmental disabilities. Unfortunately, developing such a resource is challenging as bed availability, as well as inclusion and exclusion criteria, vary for residential providers on a day-to-day basis.

Residential providers work regularly to maintain the "integrity" of their milieus, balancing the severity of residents with certain behaviors at a given time. They also express concern about repercussions, including licensing penalties, should the severity of the residents in the milieu extend staff beyond capacity or capability, resulting in adverse events. Rates for residential providers may not be sufficient to allow development of appropriate space and staffing to extend their milieus, especially given shortages of licensed mental health professionals. These challenges are then faced by CSAs and other entities supporting the youth and family to complete applications for multiple residential providers, both in and out-of-state, in a time-consuming effort further delaying placement.

Workgroup Recommendations

The workgroup developed the following seven recommendations to improve the approval and placement process for children's residential services.

1. ***Improve the alignment of the IACCT and FAPT processes to ensure efficient, timely, and better coordinated access to residential placement.***

   This recommendation includes establishing clear and definitive accountable entities for ensuring the youth receives the care needed, alignment of funding and requirements, assessor requirements, defining roles and responsibilities, and establishment of shared goals. The IACCT and FAPT processes must establish a shared process for expedited referrals for children and adolescents who are being referred to residential treatment from acute inpatient psychiatric facilities. This expedited process must include referral and funding to support step-down child and family services while awaiting residential treatment to avoid an unnecessary, prolonged stay within an inpatient setting.

   The Office of the Secretary of Health and Human Services (SHHR) intends to build on this recommendation around IACCT and FAPT and support the development of a plan to align and expedite the approval and placement process through IACCT and FAPT. This will include directing specific changes for both the IACCT and FAPT processes based on the identified opportunities for improvement.

   With regard to IACCT, one of the solutions raised by the workgroup included increasing the reimbursement rates for IACCT assessors, which would help meet the need for additional assessors. Additionally, the workgroup emphasized the importance of increasing the number of Magellan of Virginia Residential Care Managers to reduce front-end administrative duties within IACCT process and assist with placing youth with

complex treatment needs and for additional care coordination throughout the entire process. Additional care coordination while the youth is in placement will allow for increased oversight regarding progress towards treatment goals, family engagement, and discharge planning.

Regarding FAPT, the workgroup suggested assessing relevant FAPT processes and developing statewide standards for timeliness. It was noted, however, that with 130 distinct CSAs, assessing each unique process would require significant time and resources. Additionally, the efficacy of developing statewide standards depends on each CSA's capacity to adhere to those standards. While many CSA coordinators report timeframes consistent with the IACCT and the ability to offer emergency reviews, some FAPTs may not have sufficient resources to meet with increased frequency without additional resources being made available. Additional suggestions included more staffing at OCS or another state agency to provide support to FAPTs and serve as a "Medicaid Liaison" as well as a centralized, statewide hub that Medicaid, local CSA programs, local departments of social services, and families could leverage as a single point of referral and placement coordination. Both of these suggestions would require additional state resources.

Further attention needs to be given to these recommendations, including the resources and statutory authority to make these changes. SHHR intends to work with OCS and DMAS and other relevant stakeholders to understand reasonable next steps to address these identified needs. In the meantime, immediate steps that can be taken to initiate the alignment include requiring additional regular reporting of IACCT extensions, including rationale, as well as requesting CSAs report on the time from referral to placement. There should be a consideration of balancing adding administrative responsibilities versus making additions that improve the overall process and experience for the family and youth.

2. ***Improve information sharing across the system of care to ensure timely, relevant, and necessary information about the individual and family seeking residential placement is received by involved stakeholders.***

   One key theme throughout the workgroup was the importance of strong relationships among CSAs, IACCTs, residential providers, and other partners in the residential system. These relationships, including protocols for information-sharing, are critical to ensuring the process runs as smoothly as possible. One suggestion was to require a "warm hand-off" from IACCT to FAPT. Currently, FAPTs are immediately notified by IACCTs regarding a youth referred to residential treatment. However, including a consent form to share information between the FAPT and the IACCT provider can help speed the information sharing between the IACCT and the FAPT if the family consents. While this release would not give FAPTs consent to reach out to the family, they could still utilize information from the IACCT in their eligibility determination. For non-Medicaid youth, the FAPT should prioritize giving a warm handoff to the IACCT to streamline information sharing regarding Medicaid eligibility. This should be prioritized to reduce the burden on the family to provide duplicate information.

Additionally, localities currently have the ability to contract with Magellan to serve as the IACCT. This would prevent communication barriers between IACCT and FAPT and potentially create a single entry and authorization point. However, there has never been more than one such arrangement, and the requirements were not seen as practicable by local CSAs in part due to the reimbursement rate and burden on local staff. OCS and DMAS can collaborate on potential strategies for increasing the number of FAPTs serving as IACCTs. Finally, IACCT assessors could participate virtually (and some already do) in FAPT meetings which can begin to occur in the short-term.

These potential solutions can be implemented in the short-term through coordination with DMAS, Magellan, and OCS.

3. ***Standardize the training and education materials provided to individuals, families, and other stakeholders, to provide comprehensive and uniform information about the referral and admissions process to children's residential treatment programs.***

   This work will begin by defining or clarifying the roles of different involved parties in the system as is, including the IACCTs, FAPTs, residential providers, acute care providers, CSBs, and more. This will enable greater transparency and education around the process. The workgroup supported developing a "one-stop shop" guidance document or web page to serve as a resource for families on the entire residential system. This resource would be a person-centered, plain language guide designed to walk families through the various steps of the process and that providers could use to assist families. For example, having CSB contact information and the role of the case manager in bringing a case to FAPT for service planning could be clearly outlined for families in need of services. Part of this resource could include standardized residential criteria that is available to families as well as possible community alternatives.

   Significant study, planning, and coordination among DMAS, Magellan, and OCS would be required to develop these resources. However, greater transparency around the process can help to ease the burden on Virginia's families in navigating residential approval and placement. Additionally, it would allow partnerships to develop for training, including a comprehensive training targeting acute inpatient providers and community-based services providers.

   Developing comprehensive guidance, standardized criteria, and subsequent trainings should come from the additional study, led by SHHR, referenced in Recommendation #1.

4. ***Standardize the admissions referral material through a universal application process to decrease the administrative burden on individuals, families, referring agencies, and treatment providers who are seeking timely admission to children's residential treatment.***

   One of the key opportunities that could facilitate more timely placement includes streamlining the application process local CSAs and other referring providers undertake to identify a placement at a residential facility. This is particularly time-consuming when

the CSA or other entity (at times, the family) must apply to provider after provider, entering relevant information in varying formats. One key recommendation was the development of a universal application process. To develop the universal application, a small task force should be formed consisting of residential providers, OCS, and CSAs, DMAS, MCOs, Magellan, acute inpatient providers, and family representation.

5. ***Continue to build out the comprehensive continuum of care for the behavioral health system to increase access to, and availability of, alternatives to residential and inpatient treatment.***

   A fully developed community-based system of care can lead to less reliance on residential treatment as well as better outcomes when residential treatment is the best course of action for a youth. As described previously, continued investment in STEP-VA and BHE – specifically, partial hospitalization, crisis stabilization units, intensive outpatient, mobile crisis services, and intensive care coordination –with an eye toward developing a strong community-based continuum of services across the Commonwealth for children and adolescents, is critical to increasing access to less restrictive alternatives and freeing up residential space for those who need that level of care. Ideally, youth in need of services can receive those services, along with case management, in their home communities and schools. Residential placement should only be considered after all other lesser restrictive options have been explored.

6. ***Increase the availability of residential treatment facilities (including those that specialize in evidence-based treatment for specific disorders or complex needs) so that individuals and families have an informed choice of the right provider to meet their needs.***

   When placement in a residential facility is necessary for a child or adolescent, identifying an available placement should be simpler. One solution raised was developing a provider directory of PRTFs and therapeutic group homes or coordinating with OCS on how the existing Service Fee Directory can be used for this purpose. This directory should require self-reported provider specialties. DBHDS can begin this work by publishing the list of licensed children's residential providers broken out by psychiatric residential treatment facility or therapeutic group home. This list is available in Appendix C.

   Additionally, investment in an enhanced bed registry tool, considered by the HB1453/SB739 Bed Registry workgroup, which includes provider specialization and clinical inclusion/exclusion criteria, could help generate a clearer picture of bed availability among children's residential providers.[5] Ideally, an enhanced bed registry tool would include varying user permissions, which could enable CSAs to access this information as they participate in the residential facility placement process.

   Not only is a better understanding of the availability of children's residential placements and their respective specialties critical, so is increasing their accessibility in Virginia and ensuring adequate availability of the specialties that Virginia's youth need. A Medicaid rate study of children's residential rates was completed, and a recent rate increase went through in the Appropriation Act. It was noted by workgroup members, however, that

[5] Acute Psychiatric Bed Registry Workgroup Report. (Nov 2020). Available at: https://rga.lis.virginia.gov/Published/2020/RD513

rates still may not be sufficient to cover the additional costs incurred for youth who require a higher than typical level of staffing, additional space (e.g., single room), and specialized clinical providers. To start, an analysis of where there are gaps in current coverage in Virginia would help to identify options to incentivize facilities to treat these populations. This analysis could be used to explore the possibility of an enhanced Medicaid rate for higher need youth. This suggestion would require various legal and regulatory measures as well as investment on behalf of the General Assembly. Furthermore, "no reject, no eject" contracts could be developed to require that the residential facility accept these youth if a bed were available and that if the child needed to receive short-term inpatient care while in the residential facility that they could return to their placement. This would also require investment as well as possible legal or regulatory modifications.

7. ***Increase the use of family support partners and peer navigators to provide support and improve timeliness in accessing services.***

   Finally, the workgroup heard from a Family Support Partner (FSP) from a residential provider about her role helping to navigate youth and their families through residential treatment. The workgroup noted that expanding the role of FSPs to beginning their work upon initial referral and assisting youth and families throughout the placement process could help to streamline and expedite the process and remove the burden on families. FSPs could be contracted to work with the youth and their family through the FAPT process, to the placement at a residential facility through discharge from the residential facility and identification of additional services. Currently, a Magellan Family Support Coordinator is supposed to be assigned to every family going through the IACCT process, though this is specific to the IACCT process only. Recruitment for these positions is challenging. A long-term investment in developing the family support workforce as well as a rate increase for family support, whether the person is employed through Magellan or a separate organization, services is essential to improving the availability of these services to families. A Peer Recovery Support Services workgroup (including FSP services) was initiated and is currently being facilitated by DMAS during FY21 to determine if regulation changes could assist with access to peer services.

Summary of Recommendations	
Short-term actions	**Long-term planning and investment**

- Sharing a list of residential facilities
- Regular reporting of IACCT extensions with associated reason
- Request to local CSAs to report regularly on average time from referral to placement
- DMAS-OCS coordination on FAPTs serving as IACCTs
- DMAS-OCS coordination on IACCT assessors participating in FAPT meetings
- Convening of a task force to develop a universal application
	- SHHR-led task force to align and improve IACCT and FAPT processes, including:
	  ○ Defining roles of key players
	  ○ Developing standardized residential criteria
	  ○ Identifying additional opportunities for alignment and expediting the process
	- Continued investment in the comprehensive continuum of care
	- Enhancement of the bed registry tool
	- Increased or specialized residential Medicaid rates
	- Investment in Family Support Partners

Conclusion

The process for approval and admission of children and adolescents into residential treatment is complicated and time-consuming. There is a need to develop greater clarity around the process and identify additional opportunities for expediting the process without bypassing consideration of less restrictive placements. In the short-term, there is work that state agencies can do to promote transparency and coordinate on various solutions. In the long-term, additional study as well as stepwise, meaningful, and comprehensive changes are needed, including investment in the availability of community-based services which will, over time, lead to decreased reliance on costly levels of care and better outcomes for Virginia's youth. Ultimately, consideration of the impact of the approval and admissions process on Virginia's families should be top-of-mind as solutions to increase transparency and awareness, expedite various steps, and help families to navigate the process through increased supports like FSPs are implemented.

Appendices

Appendix A: Workgroup Participants

Co-chairs:

Alison Land, FACHE — Commissioner, DBHDS

Dr. Karen Kimsey — Director, DMAS

Office of the Secretary of Health and Human Resources: Dr. Vanessa Walker-Harris

Workgroup Members

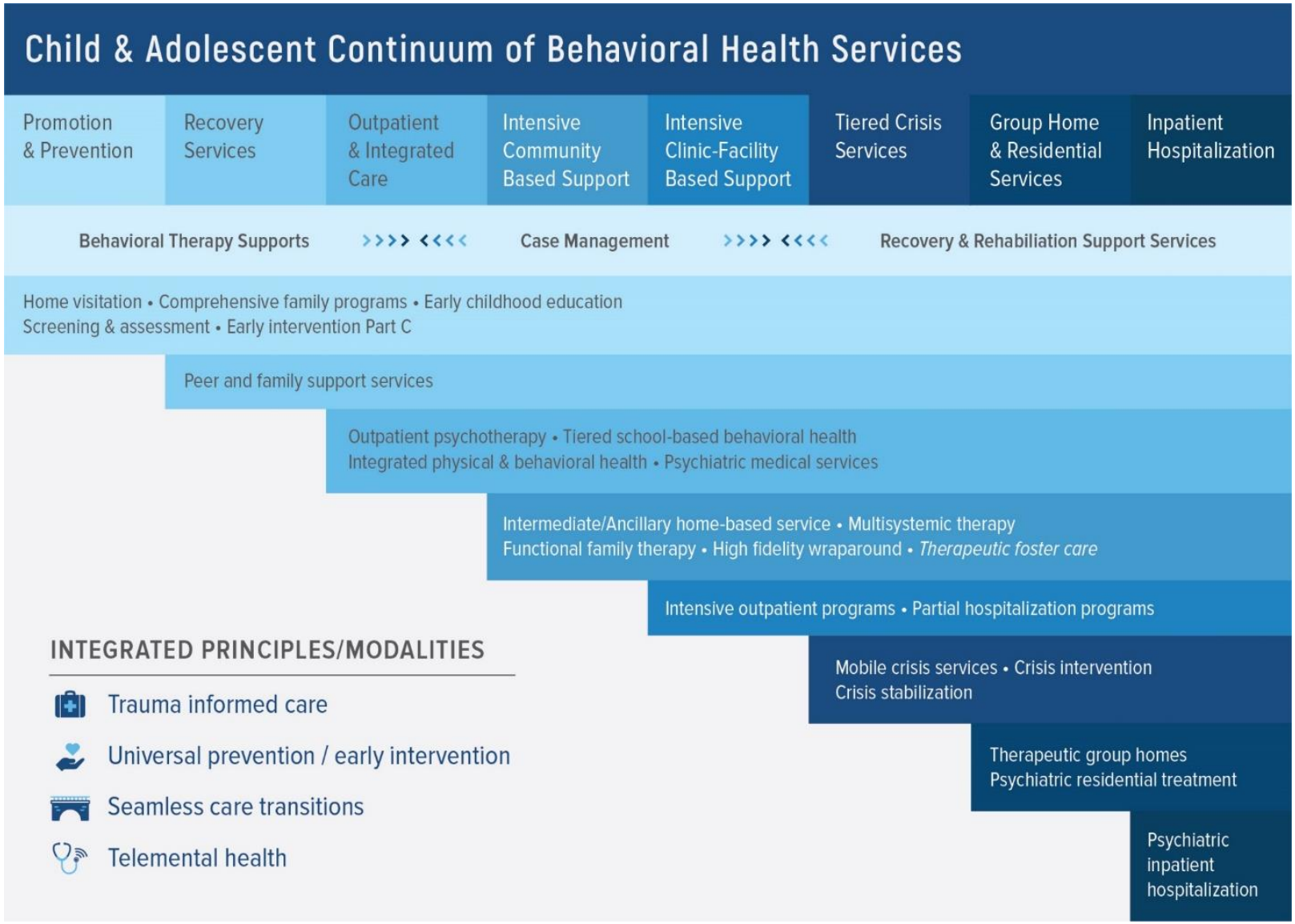
Harry Keener	Aetna
Lauren Bayes	
Anne Catlett	Anthem
Kathleen Beers	
Stephanie Osler	Children's Hospital of The King's Daughters
Julie Payne	City of Roanoke
Beth Stinnett	Department of Juvenile Justice
Elizabeth Overall Lee	Department of Social Services
Ron Spears	Elk Hill
Dr. Janet Bessmer	Fairfax County CSA
Jennifer Switzer	Family Insight
Mike Schaefer	Gateway Homes
Mills Jones	Goochland County CSA
Scott Zeiter	Grafton
Natalie Elliot	Intercept Youth Services
Amy Croft	Magellan Behavioral Health Services Administrator
Dr. Tricia Van Rossum	
Priscilla Smith	Magellan Complete Care
Bruce Cruser	Mental Health America of Virginia
Beth Tolley	National Alliance on Mental Illness Virginia (NAMI-VA)
Carolyn Wood	
Kathy Harkey	
Sondra Ramsey	Optima Health
Danette Hurst	
Michael Triggs	The Hughes Center
Lisa Castro	Three Rivers Behavioral Health Center
Karen Riccardi	United Healthcare Community Plan
Steven Dixon	
Dani Halbleib	United Methodist Family Services

Jane Vaught	
Nancy Toscano	
Pamela Daniel	
Katie Boyle	Virginia Association of Counties
Jennifer Wicker	Virginia Hospital & Healthcare Association
Kathryn Jones	Virginia Association of Child and Adolescent Psychiatrists
Mindy Carlin	Virginia Association of Community Based Providers (VACBP)
Jennifer Faison	Virginia Association of Community Services Boards (VACSB)
KJ Holbrook	
Paulette Skapars	
Bill Ellwood	Virginia Coalition of Private Provider Associations (VCPPA)
Jessica Vermont	Virginia Premier
Dr. Alexandria "Sandy" Lewis	Virginia Treatment for Children
Ashley Airington	Voices for Virginia's Children
Dr. Courtney Gaskins	Youth for Tomorrow
Chris Bohn	Parent Representative

State Agency Representatives

Alex Harris	Department of Behavioral Health and Developmental Services
Dr. Alexis Aplasca	
Heidi Dix	
Nina Marino	
Pam Fisher	
Shannon Wilson	
Henry Millward	Department of Education
Karen Schonauer	
Beth Stinnett	Department of Juvenile Justice
Dr. Alyssa Ward	Department of Medical Assistance Services
Laura Reed	
Shamika Ward	
Em Parente	Department of Social Services
Anna Antell	Office of Children's Services
Scott Reiner	

Appendix B: Child and Adolescent Continuum of Behavioral Health Services



Appendix C: Licensed Residential Providers in Virginia by Region

Region	Provider Organization	Distinct Provider Count
1	Centra Health, Inc.	1
	Childhelp USA	1
	Elk Hill Farm, Inc.	1
	Fair Winds	1
	Grafton Integrated Health Network	1
	Intercept Youth Services, Inc.	1
	Liberty Point Behavioral Healthcare, LLC	1
	Little Keswick School, LLC	1
	Restorative Youth Services	1
	STARS	1
	Timber Ridge School	1
	Region Total	**11**
2	Center for Discovery	1
	Clementine Twin Lakes, LLC	1
	North Spring Behavioral Healthcare, INC.	1
	Second Story	1
	Virginia Health Operations, LLC dba Newport Academy	1
	Youth For Tomorrow	1
	Region Total	**6**
3	Center for Discovery	1
	Gift of Hope	1
	HopeTree Family Services	1
	Intercept Youth Services, Inc.	1
	L & G Support and Resources	1
	Pathways Youth Services III	1
	Southstone Behavioral Healthcare Center, LLC	1
	Region Total	**7**
4	All Around Achievers, LLC	1
	Blandford Family Services, LLC	1
	Cumberland Hospital, LLC	1
	Elk Hill Farm, Inc.	1
	Gatewood Children's Homes, Inc.	1
	Grace Haven Management, Inc.	1
	Grafton School, Incorporated	1

	Hallmark Youthcare - Richmond, Inc.	**1**
	Impact Adult Services	**1**
	Intercept Youth Services, Inc.	**1**
	Jackson-Feild Homes	**1**
	Kids in Focus	**1**
	NDUTIME Youth and Family Services, Inc.	**1**
	OLA Home for Boys, LLC	**1**
	Open Arms Family Services, Inc.	**1**
	Optimum Youth Service, LLC	**1**
	Outreach Services, LTD	**1**
	Poplar Springs Hospital	**1**
	Rest Assured, LLC	**1**
	RISE UP, LLC	**1**
	Safe Haven Transitional Youth Services, LLC	**1**
	Secure Haven Youth Services, LLC	**1**
	Three Rivers Treatment Center, LLC	**1**
	T-Lab, Inc.	**1**
	United Methodist Family Services	**1**
	Youth Pathway, LLC	**1**
	Region Total	**26**
5	Brighter Days Family Services, LLC	**1**
	Divinely Directed Services, Inc.	**1**
	Harbor Point Behavioral Health Center	**1**
	Holiday House of Portsmouth, Inc.	**1**
	Intercept Health	**1**
	Kempsville Center for Behavioral Health	**1**
	Newport News Behavioral Health Center	**1**
	Paramount Youth Services, Inc.	**1**
	Purvis Network, Inc.	**1**
	Riverside Behavioral Health Center	**1**
	St. Mary`s Home for Disabled Children, Inc.	**1**
	The James Barry Robinson Institute	**1**
	Region Total	**12**
State Total		**58**