DoHS Residential Reform FAQ

Proposed Effective Date: October 1, 2024

Number	FAQ	DoHS Response	Reference to State Plan Amendment (SPA) Public Comment

1.	Can this process be slowed down and worked through collaboratively with provider input and feedback to ensure a positive, safe, and equitable outcome for all?
	
	Would the Department of Human Services (DoHS) consider a collaborative approach with providers to introduce new concepts with a phased or pilot approach?
		Since 2022, DoHS has met regularly with residential providers and interested parties regarding residential reform efforts. Meeting attendees include, but are not limited to:
		• Jacob Green, Superintendent, West Virginia Department of Education (WVDE)
		• Todd White, Chief Executive Officer and Kathy Szafran, Executive Director, Aetna Better Health® of West Virginia (Aetna)
		• Staff with the Division of Children's Services, Supreme Court of Appeals of West Virginia
		  ○ Cindy Largent-Hill, Director
		  ○ Keith Hoover, Deputy Administrative Director & Counsel
		  ○ Gabriel Conley, Court Improvement Program Field Coordinator
		• Residential provider agencies
		On October 6, 2022, during an in-person meeting with residential providers and interested parties, the group decided to form six sub-groups to work on challenges related to residential services. One of the six sub-groups was to focus on high acuity level of care. The subgroup began meeting in February 2023.
		In August 2023, DoHS's partnership with Casey Family Programs assisted the group with peer-to-peer and on-site visits to comparable facilities in Iowa.
			3, 23, 37, 49, 50, 57, 60, 61

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		The draft program model and initial proposed rates were released to the residential providers and other interested parties on November 1, 2023. Since the release of the initial program model and rate, DoHS leadership has met weekly with residential providers and interested parties. Additionally, leadership has met individually with providers, including on-site visits as requested by various providers. These meetings have led to rate increases based upon the provider's feedback. DoHS has delayed the target implementation date from July 1, 2024, to October 1, 2024, to allow additional time for readiness. Technical assistance will continue to be provided throughout implementation through partnerships with Casey Family Programs and the Building Bridges Initiative, per request of the West Virginia Child Care Association. DoHS anticipates an implementation date of October 1, 2024, dependent on internal and external state agency review, the approval of the Governor's office, and the Centers for Medicare and Medicaid Services (CMS) approval of the SPA.	
2.	What is the process to become a licensed behavioral health center (LBHC)?	There is overarching guidance in Medicaid Chapter 503 related to LBHC credentialing process. DoHS is developing a detailed checklist to offer additional guidance to interested parties that may	7

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		wish to become an LBHC. The checklist will be distributed by mid-June 2024.	
3.	Will DoHS adjust rates prior to implementation and commit to annual rate adjustments within contract language? Is the Cost Report Data submitted by provider agencies available for public review?	An actuarial rate analysis was conducted to support the rate development. The initial rates were developed with information gathered through provider survey responses and recent provider cost reports. Following the November 2023 presentation of the rates, rate increases were made based upon provider feedback. DoHS will not adjust rates again prior to implementation; however, DoHS will complete an annual review to identify potential process or program needs, policy updates, rate changes, and other identified issues. DoHS will collaborate with providers of Residential Intensive Treatment (RIT) and Specialized Residential Intensive Treatment (SRIT) to develop a modified cost report to assist in the annual review. Information related to the cost report survey conducted by Myers and Stauffer, LLC, is available online at West Virginia Department of Health and Human Services Provider Portal | Myers and Stauffer (myersandstauffer.com)	10, 24, 25, 42, 43, 62, 63, 64, 76, 77
4.	Will DoHS and Aetna establish an application process that is equitable and transparent to help support transition costs?	Aetna confirmed during office hours that information was sent to providers regarding funding and how to contact Aetna with a request. Kathy Szafran encouraged anyone that may not have received the email to contact her at szafrank@aetna.com.	11, 12, 13, 33, 45, 48, 51, 53

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5.	Can the criteria for the Residential Home model be modified for those who do not meet the medical necessity requirement?	The Residential Home model is designed to support children who no longer meet criteria for a residential treatment intervention or who are experiencing permanency challenges or both. The Residential Home model will serve children ages 5 – 16 who have undergone assessment and have been determined to need this type of intervention assistance and are presenting with the following factors: • Need a family or family-like setting • Have experienced failed foster or adoptive care placements • Require engagement or integration into the community • Need appropriate adult relationships • Experience social functioning deficits • Current treatment needs can be met in the community on an outpatient basis. These treatment services will be billed separately through Medicaid by a community-based service provider.	14, 59
6.	Has DoHS determined any possible impact the IMD (Institution for Mental Diseases) rule may have (e.g., loss of funding)?	DoHS will continue to communicate with CMS to alleviate any concerns regarding the IMD rule. This is a nationally recognized concern that CMS continues to work individually with states.	15, 16, 17, 18, 54
7.	What is DoHS doing to reduce the risk to WV's residential system of care? e.g., loss of beds,	There is no plan to move children out of existing placements upon implementation of the new models of care. Current placements will discharge according to their plan of care and new referrals will be required to meet the new model of care admission criteria.	19, 20, 21, 58, 61, 75, 79, 80, 81, 82, 83, 84

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	instability of system, support in-state providers to care for high needs children?	DoHS requested transition guides from residential providers to be submitted by April 30, 2024; to help identify the number of beds and service models each agency plans for October 1, 2024. Licensing specialists are working with each agency on their planned service models. Aetna and DoHS leadership have met with providers individually to discuss any instability concerns they may be experiencing as they transition into the new models of care. Providers are encouraged to reach out to Aetna and DoHS leadership to discuss their concerns. Aetna has started meeting individually with each provider to review their current children in care, to work to ensure children are in the appropriate level of placement and help to facilitate discharge plans when appropriate.	
8	Where will children currently being served in Level 1 and 2 settings be placed?	Once the new models of care are in place, children who are experiencing permanency challenges and have traditionally been served in Level I and II will be served in Residential Homes. Children who are experiencing mental health and behavioral health needs that cannot be met in their community and have traditionally	34

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		been served in Level II and III will be served in RIT or SRIT programs.	
9.	Is a bed vacancy rate being considered that would preserve the ability for all residential providers to keep solid staffing ready and available for referrals?	Vacancy rates were factored into the per diem rates with an average occupancy rate of 86.69%.	22, 61
10.	Can there be a monthly service or case rate for add-on services versus billing individual services at 15-minute increments through Medicaid?	Additional services, which are billed as “add-ons” units, will be billed under the fee-for-service model as defined in Chapter 503. Please see Appendix A which identifies the service and how the “add-on” units are billed. The units vary and are not necessarily 15-minute increments. Appendix A will be finalized with Chapter 503 revisions.	26, 51
11.	How does the SPA address least restrictive environment possible with the only option being high intensity?	The Qualified Independent Assessment (QIA) process is in place to identify the most appropriate least restrictive setting. DoHS is committed to working to ensure children receive the appropriate treatment intervention in the least restrictive setting. RIT and SRIT models are designed to provide intensive treatment for children who need out-of-home intervention.	31, 80, 82

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		Research indicates most benefits in residential treatment are made in the first three to six months.[1]	
12.	What is DoHS doing to help ensure home and community-based services are available and adequate throughout the state?	DoHS works closely with the managed care organizations (MCOs) on network provider adequacy and provider recruitment. Home and community-based services, including the Children with Serious Emotional Disorder (CSED) Waiver and WV Wraparound, are continuously evaluated to help ensure providers are available statewide. Please see the DoHS Children's Mental Health and Behavioral Health Services Quality and Outcomes reports on the Kids Thrive Collaborative website located here: DOJ Partnership (wv.gov). The April 2024 addendum provides additional information on several areas including Children's In-Home and Community-Based Services Improvement Project Evaluation and Wraparound services. The next semiannual report will be published on July 31, 2024.	32, 50, 75, 81, 82, 83

[1] Magellan Health Services (2008). These findings are supported by latent class analyses of youth placed in group care in other states like Arkansas, Montana, and Texas. See for example:

- Chadwick Center and Chapin Hall. (2016). *Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare*. San Diego, CA & Chicago, IL: Authors.
- English, D.J., & Pecora, P.J. (2017). *Effective Strategies for Serving Montana Youth with Different Levels of Need.* Seattle: Casey Family Programs. Retrieved from https://www.casey.org/residential-care/
- Romani, E., Pecora, P.J., Harris, B., Charlotte, J., & Stanley, *A.* (2018). A systems analysis of youth in acute and subacute therapeutic residential care. *Journal of Public Child Welfare. Retrieved from:* https://www.tandfonline.com/doi/full/10.1080/15548732.2018.1498429

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		To support expansion and sustainability of children's mobile crisis services, the Bureau for Medical Services (BMS) began offering Community-Based Mobile Crisis Intervention Services, as a Medicaid covered service effective February 1, 2024. Please see BMS Chapter 503 H for additional information found here: Appendix 503H Community-Based Mobile Crisis Intervention Services Planned implementation of Certified Community Behavioral Health Clinics (CCBHCs) statewide effective October 1, 2024, will also increase the availability of children's mental health services across the state. DoHS in partnership with Mission West Virginia, the West Virginia Child Placing Agencies, and Aetna launched a campaign focused on recruitment of foster homes for older youth.	
13.	Why is the focus on reducing length of stay when some treatment takes more time?	The focus is to provide residential intervention at a level needed for the child to return as quickly and as safely as possible to their family and community for community-based treatment and services. The timeline for each child will vary based upon their assessed needs and treatment plan with the goal being no longer than 90 days. The actual length of stay for each child will be individualized and based upon the diagnosis and actual treatment needs of the child. As noted in Response 11, research indicates most benefits in residential treatment are made in the first three to six months.	35, 36

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14.	How will increased service requirements be met with various outside factors including workforce shortages, staff coverage for training and vacation, academic requirements, etc.	Personnel expenses were included in the rate development based upon the providers survey responses.	38, 39, 40, 51, 52
15.	Why is nighttime supervision identical to daytime? What is the intent of having multiple staff watch sleeping children?	DoHS determined nighttime staffing ratios based upon feedback from residential providers regarding behaviors that often occur at night. The rate development includes the consideration of nighttime staff to support this level of supervision.	41
16.	Is there flexibility for accommodating current providers unable to meet new model requirements effective October 1, 2024? e.g., more than one child in a bedroom or exceeding the total number of children in the facility.	There is no plan to move children out of existing placements upon implementation of the new models of care. Current placements will discharge according to their plan of care, and new referrals will be required to meet the new model of care admission criteria. DoHS will review provider requests for a variance or waiver from program requirements on a case-by-case basis.	44, 45, 46, 57, 72

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17.	Can you clarify if Evidence-Based or Evidence Informed curriculum is required? Are there accepted evidence-based models?	The RIT and SRIT models of care require an evidence-based trauma informed curriculum. In the program design document, DoHS has examples of approved evidence-based trauma informed curricula. Providers may submit other nationally recognized evidence-based trauma informed curricula to DoHS for review and approval. Please see Appendix B for the approved evidence-based models.	68, 70
18.	Has the model proposed in the SPA been successful elsewhere? Where are the supportive data outcomes?	DoHS worked with subject matter experts from the University of Maryland, Chapin Hall, and Casey Family Programs to develop the RIT and SRIT models. Similar models have been used in New Jersey and Iowa. The New Jersey and Iowa goals align with West Virginia's which is to reduce out-of-state placements and reduce the average length of stay. Iowa staff shared the following outcomes with DoHS: • The length of stay in the specialized model is shorter. Twenty percent of children move to a community-based facility within 90 – 120 days, while in the previous model children experienced length of stays over one year. • In March 2023, there were no children placed in out-of-state residential group facilities and only 20 children in out-of-state Psychiatric Residential Treatment Facilities.	71

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		The New Jersey model is focused on community-based, family-focused care in the home with placement and hospitalization only as a last resort. • Published data shows a 97% reduction in out-of-state placements between March 2006 and June 2011. • As community-based alternatives were made available the percentage of children receiving residential care decreased from approximately 35% in 2002 to 10% in 2009. • Family satisfaction with the model improved over time and increased from approximately 60% to nearly 80% within five years. • The full New Jersey report can be found here: DCF (nj.gov)	
19.	How will DoHS cover the increased costs of services as outlined in the SPA, with Title IV-E funds. Can DoHS provide detailed information regarding these increased costs, including any and all loss of matching IV-E funding?	The estimate included in the Medicaid SPA notice represents only the total cost to the Medicaid program for RIT and SRIT services. The estimate reflects the expected placement of children and youth based upon the assumption they will be served in settings closely matched to their placements in FY2023; therefore, the total Medicaid cost for RIT and SRIT includes the majority of children and youth currently in Levels 3 and 3.5 as well as a portion of those served in Level 2. Most children and youth in Levels 1 and some in Level 2 will be served in community settings (family-like homes or Residential Homes), with the room and board and supervision cost borne by the Bureau for Social Services. Children and youth eligible for Title IV-E will continue to receive federal maintenance assistance payments, which is supported at the same level as the Medicaid federal medical assistance percentage (FMAP). Since the	85

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		publication of the SPA notice, the Department continues to refine the projected costs based upon stakeholder feedback. The cost savings will come from the decreased length of stay for children and youth receiving treatment in all types of residential care.	

Appendix A: Medicaid Add-On Chart for RIT and SRIT

Prior authorization of services is determined by the managed care organization the individual is enrolled in as a member. Rates in the chart below are as of February 26, 2024, and are subject to change as determined by DoHS.

Service description	Procedure Code	Modifier	Unit	Unit Limits	Rate	Additional Description Detail
Behavioral Health Counseling, Professional, Individual	H0004	HO	15 min	60 units per year	$32.38	Documentation of service utilization must include that the individual has utilized 10 hours of therapy services within the calendar week in one or more of the following services: individual, family, and group therapy. All services must be documented and supported in the individual's plan of care. Available GT modifier
Family Psychotherapy	90846 90847		45-50 min		$71.12 – Facility $71.37 – Non-Facility $74.32 – Facility $74.81 – Non-Facility	Documentation of service utilization must include that the individual has utilized 10 hours of therapy services within the calendar week in one or more of the following services: individual, family, and group therapy. All services must be documented and supported in the individuals plan of care. Therapy services provided exclude instances when the service constitutes taking a history or documenting evaluation and management services.
Behavioral Health Counseling Professional Group	H0004	HO, HQ	15 min	50 units per year	$6.93	Documentation of service utilization must include that the individual has utilized 10 hours of therapy services within the calendar week in one or more of the following services: individual, family, and group therapy. All services must be documented and supported in the individuals plan of care. Available GT modifier

Service description	Procedure Code	Modifier	Unit	Unit Limits	Rate	Additional Description Detail
Behavior Management Services Therapeutic Behavioral Services Implementation	H2019		15 min		$10.40	Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. Telehealth unavailable
Behavior Management Services Therapeutic Behavioral Services Development	H2019	HO	15 min		$26.99	Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. Telehealth unavailable
Mental Health Assessment Administration by a Non-Physician	H0031		Event		$151.20	Providers may request more units if a critical treatment juncture arises; however, not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services. Should be done prior to providing behavioral health services. **Approved Causes for Utilization:** 1. Intake/Initial evaluation.

Service description	Procedure Code	Modifier	Unit	Unit Limits	Rate	Additional Description Detail
						2. Alteration in level of care except for individuals being stepped down related to function of their behavioral health condition to a lesser level of care. 3. Critical treatment juncture defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or designated legal representative (DLR) and may cause a revision of the plan of services. 4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment Among other information, documentation of reassessment must include the reason for reassessment, including description of current presenting problems (must document medical necessity for evaluation.), and changes in situation, behavior, and functioning since prior evaluation. Available GT modifier
Skills Training and Development Skills training 1:1 by paraprofessional	H2014	U4	15 min		$10.50	The individual's skill deficit must be documented. All services must be documented and supported in the individuals plan of care. The plan of care must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member. Telehealth not available

Service description	Procedure Code	Modifier	Unit	Unit Limits	Rate	Additional Description Detail
Skills Training and Development Skills training 1:2-4 by paraprofessional	H2014	U1	15 min		$5.25	The individual's skill deficit must be documented. All services must be documented and supported in the individual's plan of care. The plan of care must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member. Telehealth not available
Skills Training and Development Skills training 1:1 by professional	H2014	HN, U4	15 min		$20.90	The individual's skill deficit must be documented. All services must be documented and supported in the individuals plan of care. The plan of care must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member. Telehealth not available
Skills Training and Development Skills training 1:2-4 by professional	H2014	HN, U1	15 min		$10.45	The individual's skill deficit must be documented. All services must be documented and supported in the individual's plan of care. The plan of care must identify the specific, sequential steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member. Telehealth not available
Crisis Intervention	H2011		15 min	16 unit per 30 days	$20.90	Crisis Intervention is an unscheduled, direct, face-to-face intervention with a member in need of psychiatric interventions to resolve a crisis related to acute or severe psychiatric signs and symptoms. Depending on the specific type of crisis, an array of

Service description	Procedure Code	Modifier	Unit	Unit Limits	Rate	Additional Description Detail
						treatment modalities is available. These include, but are not limited to, individual intervention and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation, stabilize, and create a plan as quickly as possible. A physician, PA, APRN, supervised psychologist, licensed psychologist, Licensed Professional Counselor (LPC), or Licensed Independent Clinical Social Worker (LICSW) must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow-up and whether the treatment plan is to be modified or maintained, the practitioner's signature with credentials, and the date of service. The signature will serve as the order to perform the service. If a supervised psychologist is utilized to provide approval for this service, the supervised psychologist must have completed an appropriate training in crisis intervention and systematic de-escalation.

Appendix B: Approved RIT and SRIT Evidence-Based Treatment Models

Examples of approved evidence-based trauma informed treatment models include:

- Children and Residential Experiences (CARE)
- The Sanctuary Model
- Collaborative Problem Solving (CPS)
- Attachment, Regulation and Competency (ARC) – System Level
- Risking Connection
- Restorative Approach
- Trauma Systems Therapy
- Other evidence-based, supported, or promising systems-level model with strong trauma emphasis reviewed and approved by Bureau for Social Services (BSS) for RIT implementation

The use of client-level interventions rated by the California Evidence-Based Clearing House as well-supported, supported, or promising to address trauma in the residential care setting.

Approved interventions include:

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Eye-Movement and Desensitization Reprocessing (EMDR)
- Prolonged Exposure Therapy for Adolescents (PE-A)
- Seeking Safety
- Cue-Centered Therapy
- Risk Reduction Through Family Therapy
- Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At Risk Treatment (SITCAP-ART)
- I Feel Better Now! Trauma Intervention Program

Specifically, for the SRIT Neurodevelopmental and Comorbid Conditions (NACC) program model the approved evidence-based treatment model is Accept-Identify-Move (AIM).

Provider agencies may provide additional nationally recognized evidence-based treatment models for review and approval by DoHS.