
Pennsylvania (Group One: State-Developed Guidelines)

- Guidelines for Mental Health Necessity Criteria (“Appendix T”) and
- Guidelines for Best Practice in Child and Adolescent Mental Health Services



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Overview

Child and adolescent behavioral health services in Pennsylvania are administered through a managed care behavioral health carve out arrangement, called HealthChoices, in which Pennsylvania’s counties have risk-based contracts with the State and may act as their own managed care organizations (MCOs) or contract for MCO functions with commercial or non profit entities. As a result of the strong county role in the delivery of behavioral health services, there is wide variation across the State in the types of managed care entities used, with some counties using government entities, some using commercial managed care companies, and some using non profit or hybrid arrangements.

With the implementation of managed care eight years ago, the State developed Guidelines for Medical Necessity Criteria for both adult and child and adolescent services; the guidelines are known as “Appendix T” as they are incorporated as an appendix within the HealthChoices manual. The purpose of Appendix T is to provide decision-making criteria for the admission, continuing stay, and discharge of children and adolescents in various treatment environments under regulation by the State Medicaid and mental health agencies. Appendix T states that “ this document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse...and Office of Medical Assistance...payment regulations, for deciding when to treat, continue or discontinue treatment.”²⁶ Appendix T covers mental health necessity criteria for the following services: psychiatric inpatient hospitalization; residential treatment; psychiatric partial hospitalization; outpatient treatment; behavioral health rehabilitation services under EPSDT—home and community-based services; Family-Based Mental Health Services Program; and targeted case management. The State uses the adolescent patient placement criteria of the American Society of Addictions Medicine (ASAM) for adolescent substance abuse treatment services.

The Appendix T criteria are broad, qualitative guidelines that are nested within an overall philosophy of system of care principles, including individualized care. While MCOs and providers are required to use the criteria, the state also allows MCOs to develop “similar but equal” criteria; State-level stakeholders indicated that, to date, no one has put forward an alternative. Any changes have to be approved by the State Department of Public Welfare. On an individual basis, a member may grieve a denial based on the application of medical necessity criteria; the second-level grievance includes a county-level person. At this level, the application of medical necessity for a particular child may be changed.

In addition to Appendix T, the State also developed “Guidelines for Best Practice in Child and Adolescent Mental Health Services.” The Guidelines describe protocols and discuss issues related to a broad range of clinical practice issues organized in three main sections: Assessment, Practice, and Behavioral Health Submissions. Like Appendix T, these are broad guidelines, and State-level stakeholders noted that MCOs and their providers typically are using

²⁶ State of Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs (04/01/2004). Appendix T: Guidelines for mental health necessity criteria. Available <http://www.dpw.state.pa.us/omap/rfp/hlthchcrfp/HlthChBHappdxTpartB.asp>.

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additional assessment and clinical decision making tools. For example, the Philadelphia County behavioral health organization is utilizing a version of the Child and Adolescent Needs and Strengths (CANS) tool to assess and guide clinical dispositions for youth involved in the juvenile justice system.

Goals

State-level stakeholders indicated that a major goal in their development of the Appendix T criteria was to ensure that the State’s system of care values would be reflected in medical necessity criteria to establish a framework for managed care companies. There was concern within the State about medical necessity criteria historically promulgated by managed care companies which was perceived to restrict access to services and require consumers to “fail first” in one level of care before being eligible to access a higher level of care. Thus, a major goal of Appendix T was to send a message and provide guidance to the MCOs. State-level stakeholders indicated that the criteria also are intended to promote consistency in clinical decision-making statewide and across diverse MCOs.

With respect to the State’s Best Practice Guidelines, the intention was to promote high quality care and provide a framework for “systematic, conscientious clinical pursuit.”²⁷ The Guidelines enable the State to articulate its “CASSP” (i.e., system of care) philosophy of care and to offer guidance to MCOs and providers on how these principles translate into practice.²⁸

Background

The Appendix T criteria were developed initially during the development phases of HealthChoices through a process supported by a national foundation grant. The State drew on the expertise of psychiatric consultants, families and others to formulate the criteria and piloted them in one county. State-level stakeholders indicated that the criteria were “out for years for review” before becoming final and that counties, through this process, are quite familiar with them.

Description

The Appendix T Mental Health Necessity Criteria are organized into four parts:

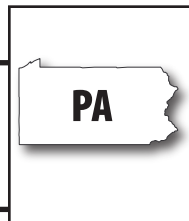
- **Part B.1** governing psychiatric inpatient hospitalization, residential treatment, psychiatric partial hospitalization, and outpatient treatment;
- **Part B.2** governing behavioral health rehabilitation services under EPSDT: home and community-based services;

²⁷ State of Pennsylvania, Department of Public Welfare (February 18, 2005). Guidelines for Best Practice in Child and Adolescent Mental Health Services. Available <http://www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines/> <<http://www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines/>> .

²⁸ CASSP stands for Child and Adolescent Service System Program, a federal initiative that promoted the development of systems of care for children, adolescents and their families that are coordinated across child-serving systems, strengths-based, culturally competent, provide services in the least restrictive setting, and create meaningful partnerships with families and youth in policy, management and service delivery.

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- **Part B.3** governing the Family Based Mental Health Services Program; and
- **Part B.4** governing targeted case management services.

Each Part is generally organized to include: an introduction; a description of the service type, its function and philosophy, and rationale for its inclusion within the continuum of care; a discussion of CASSP principles governing service provision; relevance of severity of symptoms and intensity of treatment; admission guidelines; continued care guidelines; discharge and service transition guidelines; and, documentation requirements. Admission, continuing stay and discharge criteria incorporate diagnostic criteria (e.g., presence of a DSM IV diagnosis), level of functional impairment, assessment of severity, and caregiver strengths and needs. As noted earlier, the Appendix T criteria are very broad and qualitative, covering a relatively broad array of services within a State-articulated philosophy of strengths-based, individualized service provision.

The State’s Best Practice Guidelines incorporate guidance related to assessment, practice and documentation. The Guidelines cover a lengthy list of nearly 50 subject areas including such topics as: “An Effective Interagency Team Meeting; Building Blocks of the Clinical Interview; Engaging Minority Children and Adolescents Through Respect; Expectations for All Individualized, Community-based, Enhanced Mental Health Services; Expected Practices with Wraparound Services; In Support of Genuine Parent-Professional Collaboration; Possible Clinical Indicators for Psychotropic Medication for Children and Adolescents; Strengths-Based Treatment of Children: What It Is and What It Isn’t; The Role of Natural Supports in Behavioral Health Treatment for Children; Working with Children and Adolescents Who Are Defiant; Principles of Effective Home-Based Treatment.”²⁹

Individualized, Culturally Competent Family Focus

The Appendix T Mental Health Necessity Criteria and the Best Practice Guidelines were developed intentionally to reflect the State’s commitment to a strengths-based, culturally competent, individualized approach to care that views families and youth as partners in decision-making. Also, the criteria and guidelines were developed and refined with the input of families and many other stakeholders. Throughout both documents, the State emphasizes the importance of an individualized approach to care, and specific issues related to serving racial and ethnic minority families and to partnering with families are addressed in the Best Practice Guidelines. The criteria and guidelines require an individualized service planning team (ISPT) for every child receiving residential treatment or behavioral health rehabilitation services, although the extensiveness of the teaming process will vary depending upon the intensity needs of the child/family. It also should be noted again that the criteria and guidelines are so broad that they readily accommodate an individualized approach to clinical decision-making.

²⁹ For a complete listing of topics and description of the guidelines, see: www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines

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The State monitors service utilization by age, race/ethnicity and has implemented an Early Warning System, in which one of the indicators is access to services by minority populations, recognizing that, historically, racial and ethnic minority families have experienced disparities in accessing services, particularly within managed care environments. The State also has funded efforts to improve the cultural competence of the delivery system.

Impact of Service Availability

State-level stakeholders indicated that, theoretically, it is not permitted to have “unavailable service capacity” in that counties must look for alternatives when a particular type of service is not available. The State also monitors the service capacity provided in MCO networks. However, State-level stakeholders also expressed concern that too many of the service dollars go to residential treatment and to therapeutic support staff (a type of behavioral health aide that has become synonymous, unintentionally, with the provision of wraparound services). As a result, there are few incentives for the development of different types of home and community-based services.

Training, Fidelity and Oversight

The State does not conduct training per se on the mental health necessity criteria; however, it works closely with the counties to prepare them for managed care implementation, instituting a “readiness review” process in which there is orientation and preparedness training for all of the managed care requirements, including the criteria. The State charges the counties with conducting training for MCOs on the criteria and guidelines. However, State-level stakeholders also pointed out that the State developed the criteria through a very open process and that MCOs were familiar with the criteria even before the Request for Proposals process to select MCOs. Also, Appendix T incorporates principles and a philosophy that were part of the system even prior to managed care. State-level stakeholders reported that the mental health necessity criteria are “very much part of our culture” at this point.

The State conducts extensive monitoring of the managed care system in general. It utilizes independent reviewers to do annual reviews of the MCOs, including extensive chart reviews of all MCOs. They also interview case managers, look at cost and quality issues, cost trends, and management capacity. There are quality monitoring teams for each of the MCOs, who are themselves required to develop yearly quality management plans. In addition, one of the agreements the State made in response to a lawsuit involving children’s services several years ago was to collect data on every child receiving Behavioral Health Rehabilitation Services, which include Therapeutic Support Staff, Mobile Therapy, and Behavioral Specialist Consultant. (Interestingly, State-level stakeholders believe that this requirement has led to a disproportionate emphasis on prescriber intentions—i.e., whether provider intentions are followed or not -- as a proxy for quality instead of looking at other quality criteria.)

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Experience To Date

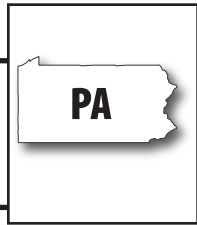
As noted earlier, Appendix T Mental Health Necessity Criteria were intentionally crafted as broad criteria partly because of concerns in the State about managed care’s tendency to implement narrow, restrictive criteria that would impede access and partly in response to strong advocacy and a history of litigation that argued for broad criteria. In the early stages of behavioral health managed care implementation, State-level stakeholders indicated that they were cautious, unsure of how managed care entities would try to control access; the State, at this early stage, required that every denial of a service, full or partial, had to come to the State for independent review. Two years ago, the State eliminated that requirement; however, denials are still reported, and the State conducts random reviews and monitors outliers. Indeed, as the State has developed experience with managed care and the Appendix T criteria, concerns have developed that the criteria are so broad that they end up being costly, in effect. However, efforts by managed care entities to tighten up the criteria have been resisted strongly by advocates. State-level stakeholders noted that providers tend to “err “ on the side of maximum rather than minimum service thresholds, and Appendix T does not establish minimum thresholds; instead, the criteria encourage individualized care. Appendix T does not incorporate formal, quantitative assessment measures, although the State more recently has encouraged managed care entities to use standardized tools. Although the State is interested in seeing MCOs use standardized tools, it also remains very committed to an individualized approach to care, and State-level stakeholders expressed the concern that, in their experience, certain tools are not as appropriate with particular populations of children. For example, they feel that the CALOCUS (now CASII) is not appropriate to use with children who have autism, and that the CAFAS does not apply as well to young children.

State-level stakeholders reported that, after eight years of experience with Appendix T, managed care entities are doing a good job of applying the criteria as the State intended. There is some concern that in continuing stay reviews, there is too much emphasis on reauthorizing rather than good clinical care management and examination of how the child is actually doing in care. State-level stakeholders expressed concern that there is too much of a bias in the system to keep children in high levels of care if they are doing well, rather than to step them down and link them to supports. Similarly, they believe there is too great a tendency in the system to “increase the dose” of a particular service if a child is not doing well rather than considering the appropriateness of the service in the first place; they noted this as an issue particularly with therapeutic support staff (i.e., TSS workers, a type of behavioral aide)—a service in which the State has experienced rising costs for several years.

State-level stakeholders believe there remains a tendency in the system to “maintain” children in treatment settings, rather than to focus on the issue of recovery. They believe this is partly because the notion of recovery and resiliency for children is relatively new and because the culture among providers and families, also supported by lawsuits over the years, is biased toward maintenance. However, State-level stakeholders also reported that they are seeing greater development of family-based programs throughout the State, which incorporate the concept of recovery and resilience and can serve as a viable alternative to TSS workers.

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The Appendix T guidelines have not been updated to date. However, State-level stakeholders reported that, currently, there are two task forces, one focusing on behavioral health services for youth and the other focusing on services for children with autism, and that changes in the criteria may result from the work of these groups.

Major Benefits, Concerns and Lessons Learned

State-level stakeholders indicated that the major benefit of their mental health necessity criteria is that they have led to, in their view, the highest levels of access to services for children in the country. On the other hand, State-level stakeholders expressed concern as to whether they can sustain the level of growth in access that they have seen over the past eight years and also whether children are receiving the appropriate level of care and types of services and supports that they need. State-level stakeholders pointed out that 80% of the State’s population is now covered by HealthChoices, and that children represent 60% of HealthChoices’ costs. They also noted that the HealthChoices behavioral health managed care carve out covers populations such as children with autism whose numbers have grown considerably over the past few years and that HealthChoices also covers children and youth who meet the definition of disability under the Supplemental Security Income (SSI) program, regardless of family income. State-level stakeholders did note, however, that particularly among the more mature MCOs, they are seeing some leveling off of costs as the MCOs become more experienced in developing new home and community-based service types. Nonetheless, the State remains concerned over high costs associated with use of residential treatment.