STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

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February 13, 2014

The Honorable Bruce Caswell, Chair
Senate Appropriations Subcommittee on DHS
Michigan State Senate
Lansing, Michigan 48933

The Honorable Peter MacGregor, Chair
House Appropriations Subcommittee on DHS
Michigan House of Representatives
Lansing, Michigan 48933

Dear Senator Caswell and Representative MacGregor:

This report is provided pursuant to the Department of Human Services' (DHS') Fiscal Year 2014 Appropriations Act, PA 59 of 2013, Article X, Section 603. This section requires that DHS report on the findings of a workgroup in conjunction with the Department of Community Health (DCH) and members from both the Senate and House to determine how the state can maximize Medicaid claims for community-based and outpatient treatment services to foster care children and adjudicated youths who are placed in community-based treatment programs.

The workgroup assembled on January 15, 2014. The workgroup included representatives from the legislature, DHS, DCH, private non-profit agencies, family court administrators, and the Juvenile Assessment Center. The workgroup discussed and agreed that community-based treatment is characterized as treatment targeted to children and youth placed in foster care or foster care group homes and attending community schools or children and youth remaining at home while under court supervision.

Medicaid treatment services available to children and youth in community settings are delivered primarily through Medicaid Health Plans (MHP) and Community Mental Health Service Programs (CMHSP). The Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) must be followed by Medicaid providers when conducting medical examinations. A mental health screening is a required element of the EPSDT. In April 2013, Michigan Medicaid policy required the use of a validated mental health screening tool for children in foster care. If the screening tool indicates a need for a further assessment, the primary care physician is responsible for making a referral to a behavioral health provider. Medicaid behavioral health services are provided by the MHP for children with mild to moderate needs and by the CMHSP for children with serious emotional disturbance (SED). The CMHSP also has programs for children with

developmental disabilities or autism. The MHPs provide or contract 20 sessions of outpatient therapy if a mild to moderate mental health need is indicated.

The workgroup identified the following concerns and questions that warrant further exploration for how the state can maximize Medicaid claims for community-based and outpatient treatment services to foster care children and adjudicated youths who are placed in community-based treatment programs:

Children And Youth With Mild To Moderate Mental Health Needs

- Although a mental health screening is a required element of the EPSDT, practice varies across the state in terms of administering the screening and providing follow-up when indicated.

- MHPs are not required to use the Child and Adolescent Functional Assessment Scale (CAFAS) that the CMHSPs use to determine eligibility for mental health services. This may increase gaps for children and youth with behaviors falling between mild to moderate and SED. Can DCH change MHP contracts to require the use of CAFAS?

- The thresholds for the screening tools may be too high, therefore excluding children and youth who could benefit from therapeutic intervention. Can these thresholds be changed?

- There is a 20-session limit for children and youth not labeled SED. Can this be changed so everyone receives coverage?

- The current talk therapy benefit may not address the child's needs. Could other therapeutic interventions, such as in-home services or wraparound be substituted for the current benefit?

- Can the CMHSP provide the mild to moderate treatment that the MHP currently provide? This change would streamline services. DCH will check if there is federal law that prohibits this.

Children And Youth With Serious Emotional Disturbance (SED)

- Different systems use different tools to measure the need for mental health services. DHS is transitioning to the use of the Child and Adolescent Needs and Strengths assessment tool. If a need for intervention is indicated on the tool, but the CAFAS does not support a need, who decides if treatment is warranted? Can the individual decide rather than the mental health professional?

- The threshold for the CAFAS may be too high, therefore excluding children and youth who could benefit from therapeutic intervention. Can these thresholds be changed? Will a change impact Medicaid funding?

- 1915B Waiver services include a rich array of interventions. Is the 1915B Waiver capped?

Youth Placed In Juvenile Justice Programs

The workgroup discussed the challenges regarding Medicaid and treatment services for youth in Juvenile Justice (JJ) programs. JJ youth placed in their own homes may not be eligible for Medicaid; treatment services may be provided utilizing private insurance or county and state funds. The workgroup also identified several concerns and questions related to the delivery of services to the juvenile justice population:

- JJ youth may not get a mental health screening or assessment up front. Can the law be adjusted to require a mental health assessment? Can the courts do the assessment?

- Mental health treatment needs to take into account the trauma experienced by the JJ youth.

- Medicaid enrollment for JJ youth, especially youth that move between community settings, and residential settings, causes delays and interruptions in treatment.
    - When youth are placed in residential care, it can take up to 45 days for the Medicaid to be reinstated, creating a cash flow issue for the facility.
    - Can the court take an active role to ensure youth who remain at home are enrolled in Medicaid, if eligible?
    - Depending on the type of setting, Medicaid may be suspended or terminated. There needs to be clearer policy about this.
    - Medicaid system changes are not made timely due to a variety of reasons: late court orders, incorrect coding, parent does not complete a new Medicaid application. Policy needs to be updated, and training needs to be provided to the courts.

Although the workgroup identified existing initiatives that address some of the concerns cited by the workgroup (New Directions, Autism Council – Crisis Management Ad Hoc Committee, Behavioral Advisory Council and the Juvenile Justice Diversion Council) further consideration is warranted on how the state can maximize Medicaid claims. It is recommended that the workgroup convene quarterly throughout the fiscal year to review the status of the aforementioned initiatives and to explore the need to formulate sub-committees to address tasks that may not be met by the efforts of existing related initiatives.

If you have any questions, please contact Wendy Campau, executive assistant to Children's Services Director Steve Yager, at (517) 241-3294.

Sincerely,

Susan Kangas
Chief Financial Officer

cc: Senate and House Appropriations Subcommittees on DHS
Senate and House Fiscal Agencies
Senate and House Policy Offices
State Budget Office