

TECHNICAL QUESTIONS RAISED DURING TECHNICAL ASSISTANCE CALLS

This log is a compilation of technical questions posed by county mental health and child welfare representatives, service providers, and other stakeholders regarding the implementation of Katie A. services: ICC and IHBS in a CPM framework. This log was created in response to the county request for a written document of the questions posed and answers provided during the weekly Katie A. technical assistance calls.

Question	Response
Screening	
<p>Does the Katie A. settlement require documentation on the CWS/CMS screening tab for referrals made as a result of an assessment performed separate from completion of a mental health screening tool? (County example: referrals made by Public Health Nurses for mental health services or developmental services for children from 0-5 years old coming into the system)</p>	<p>The Katie A settlement agreement does not include specific documentation requirements, per se. The settlement requires that children receive regular mental health screens, and when possible mental health needs are identified, referred for assessment and services. In order to ensure that these requirements are met, CWS/CMS was modified so that this data could be tracked. Developmental and mental health screenings, referrals, and plan interventions information should be recorded into CWS/CMS for children regardless of the process such a referral occurred.</p>
<p>How often should a county screen for subclass members?</p>	<p>Frequency of screenings is addressed on p. 22 of CPM Guide. Child welfare is responsible for completing a mental health screening tool at intake and at least annually. If the child welfare worker determines that there is a potential mental health crisis, he or she must make an immediate and urgent referral to mental health.</p>
<p>In order to satisfy the responsibility set forth on p. 22 of the CPM Guide, to complete a mental health screening tool at intake and at least annually, do counties have to use a separate mental health screening tool or can counties use the Structured Decision Making (SDM) tool and integrate a screening within that structure?</p>	<p>The specific tool counties use for screening is left to the counties' discretion. Counties may leverage existing processes or may create a tool to use in performing the mental health screen. A few counties created a screening tool and shared it with counties as a sample of what counties are doing. More information on screening tools can be found in the Child Welfare and Mental Health Learning Collaborative Toolkit</p>

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Subclass Eligibility	
<p>One of the eligibility criteria for Katie A. subclass members focuses on the number of placements a child or youth has had. For purposes of determining a child or youth's eligibility, how far back do you count his/her placements?</p>	<p>The placements that qualify a child or youth for subclass membership must occur within the previous 24 months. (p. 3 of the Medi-Cal Manual) Please note that the rest of the eligibility criteria must still be met.</p>
<p>If a child or youth are not in the subclass, what services are they eligible for?</p>	<p>A child or youth in the class is eligible to receive services within a Core Practice Model approach. Other Medi-Cal services (such as Specialty Mental Health Services, Therapeutic Behavioral Services, etc.) may be available to the child or youth, but eligibility would still need to be established according to the eligibility requirements for those services.</p>
<p>If a child or youth has a family maintenance case and is currently living with the biological family, are they eligible for ICC, IHBS & TFC in the CPM approach?</p>	<p>Please refer to the "open child welfare case definition" in the CPM Guide which includes any of the following: a) child is in foster care; b) child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made. (p. 49 of the CPM Guide)</p> <p>If the child meets the eligibility criteria for the subclass, they would receive ICC and would be eligible for ICC, IHBS and/or TFC within the CPM approach and/or other mental health services when medically necessary.</p>
<p>Are children or youth with private care insurance eligible for Katie A. services?</p>	<p>One of the eligibility criteria for the subclass is that the child/youth be full-scope Medi-Cal eligible. Children in private care are not full scope Medi-Cal eligible. This means that they are not subclass members, and the services would not be Medi-Cal reimbursable.</p>

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<p>What is the difference between the class and the subclass?</p>	<p><u>Class</u>: In foster care or are at imminent risk of foster care placement, have a mental illness or condition/would have been diagnosed if assessment had been made, and need individualized mental health services. (p. 51 of the CPM Guide); <u>Subclass</u>: Are full scope Medi-Cal eligible, have an open child welfare case, meet medical necessity for Specialty Mental Health Services, and currently or being considered for services (Wraparound, TFC, specialized care rates due to behavioral health needs or other intensive EPSDT services) or placements (foster care group home RCL 10 or higher, psychiatric hospital, 24-hour Mental Health facility, third placement in 24 months due to behavioral health needs). (p. 3 of the Medi-Cal Manual)</p>
<p>Are youth that have a voluntary legal guardian included in the subclass?</p>	<p>No, because they do not have an open child welfare case as defined on p. 49 of the CPM Guide.</p>
<p>Are children in Permanent Placement, where the parental rights have been terminated, eligible to be subclass members?</p>	<p>Being in Permanent Placement and/or having parental rights terminated does not preclude a child from being a subclass member. The child/youth must still meet the other eligibility criteria (see the Medi-Cal Manual p. 3).</p>
<p>Where a child meets the subclass criteria and has a history of three or more placements, but has been stable within the last 23 months and doesn't appear to need intensive services as determined by the CANS screening tool (which we utilize), are ICC or IHBS services still required?</p>	<p>Placement changes are one component of the eligibility determination, but if under a CANS assessment the child no longer meets medical necessity, then the child falls out of the subclass. The child may still be a class member, in which case even though the child would no longer receive ICC/IHBS, he/she would still receive a CPM framework for all other services being provided.</p>
<p>Do class members need to be full scope Medi-Cal eligible?</p>	<p>No, Medi-Cal eligibility is not a requirement to be a member of the class.</p>

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<p>Are class members entitled to ICC/IHBS?</p>	<p>If class members do not meet the eligibility requirements for the subclass, then ICC/IHBS services are not reimbursable. Though they wouldn't be entitled to ICC and IHBS, they may be eligible for TCM and/or other SMH services.</p>
<p>If a child is in a legal guardianship and no longer has an open case, are they eligible for Katie A. Services?</p>	<p>Katie A. services (ICC/IHBS/CPM framework) are only available to members of the class or subclass, and both sets of eligibility criteria require an open child welfare case. If the youth does not have an open child welfare case, then the youth would not be eligible for Katie A. services.</p>
<p>Are AB12 non-minor dependents eligible for Katie A. services?</p>	<p>For AB12 non-minor dependents (where a foster youth may elect to stay in foster care until age 21), the youth still has an open child welfare case, so this should not impact the process of determining whether the youth meets eligibility criteria. If they meet the eligibility requirements and are under 21, then yes, they are subclass members and must have access to services. Please note that the other eligibility criteria must still be met. More information on non-minor dependents is available on the DSS website and interested persons can review the ACL on this topic.</p>
<p>Are youth on adoptive assistance with pre-adoptive status eligible for Katie A. services?</p>	<p>Such youth could qualify for services if the other eligibility requirements are met, but once the child is adopted and the open child welfare case closes, then that child will no longer be part of the subclass and thus no longer entitled to Katie A. services.</p>

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Service Rules	
Which agency is responsible for taking the lead on providing services to the class and subclass?	Both agencies need to work together to ensure that class and subclass members are receiving appropriate services.
Is there a difference between documentation requirements for ICC services functions and TCM service functions with regards to provider notes or specific terminology?	Per p. 24 of the Medi-Cal Manual, the documentation requirements for ICC have not changed; it should be consistent with the MHPs policies and procedures and the contract between DHCS and the MHP. The documentation should include the terminology of the service functions that are being performed, an example of which would be the Child and Family Team for ICC. Where specifics were required for documentation previous to ICC/IHBS implementation, specifics will be required for ICC and IHBS.
Can ICC and IHBS services be provided over the phone?	Yes, on p. 15 of the Core Practice Model Guide, team members can communicate with one another or with the whole team in various ways, such as phone calls, conference calls, and/or emails. Furthermore, IHBS may be provided by telephone or telehealth, but providers are encouraged to provide services face to face to meet the intensity required by the child's needs.
What is the difference between TBS and ICC?	ICC is a care coordination service that requires that subclass members get services within a CPM framework, which includes teaming under the CPM principles. TBS is therapeutic behavioral service that is one on one, short term, and addresses one or two issues. A youth that is a subclass member can receive both services within the same course of treatment, but not during the same hours of the day.

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<p>Is there anything to aid counties in understanding the difference between TBS and IHBS?</p>	<p>The state recently developed a service comparison chart that sets forth the distinguishing elements of various services, including TBS and IHBS. In short, TBS is a one on one, short term service that addresses one or two behaviors that will end when the goal is met; IHBS is a focused intervention that can evolve to address the needs of the child, is not limited to short term provision, and is provided within the CPM framework.</p>
<p>Is there a list of specific activities that are provided in a Wraparound program that are not ICC/IHBS billable activities?</p>	<p>Descriptions of ICC, IHBS, and Wraparound are included in the service comparison chart. Wraparound is a planning process, not a menu of services or activities that may be provided. Activities that occur as part of Wraparound are defined by the child and family team. There is no finite list of possible activities – regardless of whether or not Medi-Cal pays for it. If activities are billable to Medi-Cal, the activities can be billed as ICC or IHBS if all of the other components of ICC or IHBS are present. If any of the components of ICC or IHBS are not present, the activities can still be paid with Medi-Cal funds, but not as ICC or IHBS. If activities are not billable to Medi-Cal, Wraparound funds or other sources may be available as the payment source. There is not a finite list of activities provided in Wraparound so as to allow counties discretion in how to provide the services. The focus must be on ensuring that the service components of ICC or IHBS are present in the activities billed to Medi-Cal as ICC or IHBS.</p>
<p>What are agencies and service providers obligated to provide to the class?</p>	<p>The class must be provided the Core Practice Model framework, which includes the Child and Family Team.</p>

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<p>Can you clarify the statements - "IHBS may not be provided to children/youth in Group Homes. IHBS can be provided outside the Group Home setting..." in the Medi-Cal Manual p. 13?</p>	<p>IHBS cannot physically be provided in a group home. IHBS can be provided to a youth placed in group home to facilitate transition in any setting where they child/youth is naturally located (home, school, recreational setting, child care centers, and other community settings) during single day and multiple day visits. Please see the Medi-Cal Manual pp. 13, 25 (conditions where IHBS can be provided), and 27 (service limitations and lockouts).</p>
<p>Can you provide ICC to a youth in group home that is not transitioning to a permanent home environment in 30 days?</p>	<p>ICC provided to a youth in group home that is not transitioning to a permanent home environment in 30 days is not reimbursable, but the youth may be eligible for other Medi-Cal services such as Targeted Case Management (TCM) and other Specialty Mental Health Services (SMHS).</p>
<p>Are class members also required to establish medical necessity for specialty mental health services?</p>	<p>A class member that needs specialty mental health services (SMHS) must meet medical necessity criteria for SMHS as defined in CCR, Title 9, Section 1830.205 and/or 1830.210.</p>
<p>Can parents/guardians decline mental health intake assessments to determine medical criteria?</p>	<p>Parents/guardians can decline services in every instance that right existed prior to the Katie A. Settlement. The Katie A. Settlement does not change Medi-Cal rules or MHPs' contracts with the State. If parents/guardians decline services, then that information should be included in the contact notes and social workers and/or providers should continue to try and work with the family to get the assessment done and get the child the help they need. If a social worker or service provider are having trouble engaging the youth or family, there are trainings available through the Regional Training Academies and additional information may be requested through the Katie A. website at KatieA@dhcs.ca.gov or KatieA@dss.ca.gov.</p>

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<p>Can the beneficiary decline services? And if so, how do providers account for this?</p>	<p>Yes, the beneficiary can decline services in every instance that right existed prior to the Katie A. Settlement. The Katie A. Settlement does not change Medi-Cal rules or MHPs' contracts with the State. If the beneficiary does decline services, then that information should be included in the contact notes and social workers and/or providers should continue to try and work with the beneficiary and the beneficiary's family to get the child the help they need. If a social worker or service provider are having trouble engaging the youth or family, there are trainings available through the Regional Training Academies and additional information may be requested through the Katie A. website at KatieA@dhcs.ca.gov or KatieA@dss.ca.gov.</p>
<p>Where a youth is receiving SMHS through a Wraparound provider in a manner consistent with the principles of the CPM, and where these services are an alternative to a group home RCL 10-14, should local agencies instruct their Wraparound contractor to bill those services as ICC and IHBS, or does the provider need to wait to bill ICC until 30 days prior to transition to a permanent home environment, as they would for group home?</p>	<p>There is no lockout for Wraparound and the lockout for group home placements does not automatically apply to a group home alternative. As stated in the Medi-Cal Manual on p 8, ICC may be provided in a hospital, psychiatric health facility, community treatment facility, <i>group home</i>, or psychiatric nursing facility solely for the purpose of coordinating placement of the child/youth on discharge of that facility and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning. The lockout applies to the listed facilities, not to group home alternatives. Wraparound does not conflict with ICC or IHBS, but in order to bill ICC or IHBS, the service components must be present. So long as the service components of ICC and IHBS are present, the services may be billed as ICC and IHBS as appropriate.</p>

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<p>Where do Licensed Professional Clinical Counselors (LPCCs) fall in Appendix G: Providers Eligible to Deliver ICC and IHBS on p. 34-35 in the Medi-Cal Manual?</p>	<p>An LPCC is a qualified provider that the state added via State Plan Amendment not that long ago. When the Medi-Cal Manual is updated this provider designation will be included, but in the meantime, LCPPs fall under the same level as a Licensed Clinical Social Worker (LCSW) and Marriage and Family Therapist (MFT). Where an LCSW and MFT can provide services, so can the LPCC.</p>
<p>When a child is a member of the subclass and the child's level of need decreases, should a provider take the child out of the subclass as he/she no longer meets criteria, or leave the child in the subclass until the 90 day review is due?</p>	<p>The review can occur at any time needed, but at least every 90 days. One of the goals of the CPM is to transition youth away from services as they are no longer needed, so providers do not need to keep the child in the subclass where their level of need decreases. This is another place good documentation is key. Providers should ensure they are documenting the transition to a lower level of care.</p>

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Question	Response
Child and Family Team	
Regarding the Child and Family Team, does the ICC coordinator have to be licensed or can a licensed supervisor sign off on the plan?	The ICC coordinator does not have to be licensed, but they do need to be able to bill Medi-Cal and usually, in order to bill Medi-Cal, a licensed supervisor needs to sign off on the progress notes and/or plan. Counties must adhere to local practices and their MHP contract. For a complete listing of providers eligible to deliver ICC and IHBS, please refer to the Medi-Cal Manual, Appendix G, pp. 34-35.
What is the role of the ICC Coordinator and does the ICC Coordinator need to be a mental health provider?	The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners are integrated to address the identified goals and objectives, and that the activities of all parties involved with service to the child/youth and/or family, are coordinated to support and ensure successful and enduring change. The ICC coordinator must be someone who can bill to Medi-Cal. (p. 7 of the Med-Cal Manual)
Does the 90 day review need to be recorded in the CFT plan and/or the Mental Health client plan?	The CFT plan can be integrated into the mental health client plan to serve the purpose of the CFT plan. If the CFT plan is changed, to address the changing needs of the child/youth and family, the overall mental health client plan may not have to be changed. Document whatever changes were made in the progress notes.
Who should be designated the CFT Facilitator?	The child and family team can designate anyone as the CFT facilitator, including the social worker, the ICC provider, the IHBS provider, another SMHS provider, or a support person to the child.
What is the difference between the ICC Coordinator and the CFT Facilitator?	The ICC coordinator provides care coordination services for all mental health diagnoses covered under the Medi-Cal SMHS waiver directed toward the child's identified mental health needs. This person must be able to bill to Medi-Cal. The CFT facilitator convenes and facilitates the CFT meeting. The facilitator can be anyone on the team, including but not limited to the ICC coordinator or an ICC provider.

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What is the difference between TDM and CFT?	The purpose of Team Decision Making (TDM) meetings is to make a placement-related decision. The Child and Family Team (CFT) is more than a meeting. The CFT is a team of people comprised of the youth and family and all of the ancillary individuals who are working with them toward their mental health goals and their successful transition out of the child welfare system. For more information on the Child and Family Team, see the Medi-Cal Manual pp. 5-6 and the Core Practice Model Guide pp. 12-16.