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SUBJECT: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions

This Informational Bulletin is intended to assist states to design a benefit that will meet the needs of children, youth, and young adults with significant mental health conditions. Children with significant emotional, behavioral and mental health needs can successfully live in their own homes and community with the support of the mental health services described in this document. These services enable children with complex mental health needs – many of whom have traditionally been served in restrictive settings like residential treatment centers, group homes and psychiatric hospitals – to live in community settings and participate fully in family and community life.

The information in this Bulletin is based on evidence from major U.S. Department of Health and Human Services (HHS) initiatives that show that these services are not only clinically effective but cost effective as well. The Bulletin also identifies resources that are available to states to facilitate their work in designing and implementing a benefit package for this vulnerable population. Developing these services will help states comply with their obligations under the Americans with Disabilities Act (ADA) and to Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, specifically with respect to mental health and substance use disorder services[1]. Many of these resources are from states, and we look forward to continuing to work with states and stakeholders to add to this resource list and to provide further assistance in assuring that children receive the care they need. Please contact John O'Brien at John.O'Brien3@cms.hhs.gov for questions about this Bulletin or to suggest additional resources.

Background

Over the past 2 decades, 2 major federal initiatives have addressed the needs of children and youth with significant mental health conditions: Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative (CMHI) and the Centers for

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[1] http://www.ada.gov/olmstead/q&a_olmstead.pdf.

Medicare & Medicaid Services (CMS) Psychiatric Residential Treatment Facility (PRTF) Demonstration Program. The CMHI program promotes a coordinated, community-based approach to care for children and adolescents with serious mental health challenges and their families. The PRTF Demonstration Program was designed to determine the effectiveness of community-based services for youth who are in, or at risk of entering, a PRTF. Both of these programs target similar children and youth who have significant mental health conditions and in some instances needing inpatient psychiatric or residential treatment.

Results from these programs have consistently found that the implementation of home and community-based services for this population have made significant improvement in the quality of life for these children, youth, and family. These have also shown a positive impact on Medicaid programs that have designed benefits for this population.

- Reduced costs of care – The PRTF evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of $40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program.
- Improved school attendance and performance - After 12 months of service, 44percent of children and youth improved their school attendance and 41 percent improved their grades as compared to their attendance and grades prior to participating in the program.
- Increase in behavioral and emotional strengths - 33 percent of youth significantly improved their behavioral strengths after 12 months of service and 40 percent after 24 months compared to their strengths as measured prior to participating in the program. Behavioral and emotional strengths include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, ability to demonstrate self-confidence.
- Improved clinical and functional outcomes - According to caregiver reports, 40 percent of children served in the CMHI program showed a decrease in clinical symptoms from when they entered the program.
- More stable living situations - The percentage of children and youth in CMHI who remained in a single living situation rather than multiple living situations during the previous 6 months increased from 70 percent at intake to 81 percent at 24 months.
- Improved attendance at work for Caregivers - Caregivers who were employed at intake reported missing an average of 6.2 days of work in the 6 months prior to participation in the program due to their child's behavioral or emotional problems. This decreased to 4.0 days at 12 months of program participation, and to 2.8 days at 24 months of program participation.
- Reduced suicide attempts - Within 6 months of service in CMHI, the number of youth reporting thoughts of suicide decreased from intake into the program by 51 percent and the number of youth reporting a suicide attempt decreased by 64 percent.
- Decreased contacts with law enforcement - For youth involved in the juvenile justice system, arrests decreased by nearly 50 percent from intake into the program after 12 months of service in CMHI.

Specific information regarding SAMHSA's CMHI program can be found at http://store.samhsa.gov/shin/content//PEP12-CMHI2010CD/PEP12-CMHI2010CD.pdf.

More information about the PRTF Demonstration including National Evaluation reports can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Alternatives-to-Psychiatric-Residential-Treatment-Facilities-Demonstration-PRTF.html.

Benefit Design

The CMHI and PRTF Demonstration programs offered an array of services to meet the multiple and changing needs of children and youth with behavioral health challenges and the needs of their families. While the core benefit package for children and youth with significant mental health conditions offered by these two programs included traditional services, such as individual therapy, family therapy, and medication management, the experience of the CMHI and the PRTF demonstration showed that including a number of other home and community-based services significantly enhanced the positive outcomes for children and youth. These services include intensive care coordination (often called wraparound service planning/facilitation), family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization, and flex funds. Each of these services is described below.

Intensive Care Coordination: Wraparound Approach
Intensive care coordination includes assessment and service planning, accessing and arranging for services, coordinating multiple services, including access to crisis services. Assisting the child and family to meet basic needs, advocating for the child and family, and monitoring progress are also included.

The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports. The wraparound "facilitator" is the intensive care coordinator who organizes, convenes, and coordinates this process. The wraparound approach is done by a child and family team for each youth that includes the child, family members, involved providers, and key members of the child's formal and informal support network, including members from the child serving agencies. The child and family team develops, implements, and monitors the service plan. Information about wraparound can be found on the website of the National Wraparound Initiative at http://www.nwi.pdx.edu/wraparoundbasics.shtml.

State specific information regarding Intensive Care Coordination/Wraparound Service Planning/Facilitation can be found at:

- https://myshare.in.gov/FSSA/dmha/caprtf/Providers/Service%20Definitions/Service_Definitions_YR_2_2008-09_50809.pdf (Indiana)
- http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html (Massachusetts)

- http://county.milwaukee.gov/WraparoundMilwaukee.htm (Wisconsin)

Peer Services: Parent and Youth Support Services

Parent and youth support services include developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities. The providers of peer support services are family members or youth with "lived experience" who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or a caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth. Almost all of the PRTF demonstration states and many CMHI projects included peer-to-peer support services for the parents, guardians, or caregivers of children and youth with mental health conditions, as well as peer-to-peer support services for youth.

State specific information regarding states' peer services for parents and youth can be found at:

http://familyinvolvementcenter.org/index2.php?option=com_content&do_pdf=1&id=3 (Arizona)

- http://rosied.org/resources/Documents/Family%20Support.program%20specs.final.doc (Massachusetts)
- http://medschool.umaryland.edu/uploadedFiles/Medschool/Departments/Department_of_Psychiatry/Division_of_Child_and_Adolescent_Psychiatry/Child_and_Adolescent_Mental_Health_Innovations_Center/RTC_Docs/COMAR%2010.09.79-FINAL.pdf (Maryland)

The CMS guidance regarding the use of peer supports for peer to peer services for parents, guardians and caregivers can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf

Intensive In-Home Services

Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and prevent out-of-home placement in inpatient or PRTF settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child and family intensively, gradually transitioning them to other formal and informal services and supports, as indicated. Information on such services from these states can be found at:

- http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314366 (Connecticut)
- http://www.mh.state.oh.us/what-we-do/provide/intensive-home-based-treatment/index.shtml (Ohio)
- http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf (Montana)

Respite Services

Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite services provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings. All CMHI and PRTF demonstrations provide some form of respite care.

Descriptions of respite services can be found at:

- https://myshare.in.gov/FSSA/dmha/caprtf/Providers/Service%20Definitions/Service_Definitions_YR_2_2008-09_50809.pdf (Indiana)
- http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/LBHPSvcsManv4b.pdf (Louisiana)
- http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf (Montana)

Mobile Crisis Response and Stabilization Services

Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise.

Residential crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family. An example from a state that provides crisis stabilization service can be found at: http://www.bhc.state.nm.us/pdf/H2011%20Crisis.pdf (New Mexico)

Flex Funds (Customized Goods and Services)

Flex funds may be used under certain Medicaid authorities to purchase non-recurring, set-up expenses (such as furniture, bedding, or clothing) for children and youth. For example, flex funds may be requested for the one-time payment of utilities or rent or other expenses as long as the youth and family demonstrate the ability to pay future expenses. Flex funds can be particularly useful when a youth is transitioning from the residential treatment setting to a family or to independent living. It should be noted that flex funds can be used for purposes other than transition, such as academic coaching, memberships to local girls or boys clubs, etc. Flex funds are only available to individuals participating in various Medicaid waivers and/or the 1915(i) program. Examples of states that have created flexible funding for goods and services for children and youth with mental health conditions are listed below:

- http://www.omh.ny.gov/omhweb/guidance/hcbs/html/FamilyFlexFundLetter.htm (New York)
- https://myshare.in.gov/FSSA/dmha/caprtf/Providers/Service%20Definitions/Service_Definitions_YR_2_2008-09_50809.pdf (Indiana)

Trauma-Informed Systems and Evidence-Based Treatments Addressing Trauma
Across the country, including system of care sites and the PRTF demonstration states, there is an increased awareness of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. More information on the ACE study can be found at: http://www.cdc.gov/ace/findings.htm

To begin addressing the trauma needs, many states are providing training and coaching for their clinicians in evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT). Many states are also exploring new policies and practices to ensure that they have trauma-informed systems of care that will be less likely to re-traumatize the children and youth they serve. To assist in developing new policies, practices, training, and coaching for trauma-informed care, a manual and documentary film is being developed in a cooperative effort with the participating states.

Additional resources related to trauma can be found on the National Child Traumatic Stress Network website at: http://www.nctsn.org/

Other Home and Community-Based Services
States have also developed service definitions for a variety of additional home and community-based services that have proven to be important for children and youth with mental health conditions to be successful in the community. This includes: mentoring, supported employment for older youth, and consultative services. These types of services may be provided through 1915(c) waivers and the 1915(i) program.

Additional information regarding the description of each of the PRTF demonstration state's service arrays and definitions, including those listed in "other home and community-based services can be found in the 2008 Implementation Status Report at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/CBA-Implementation-Status-Report-Final.pdf

Medicaid Authorities and Demonstration Programs

States have significant flexibilities in the Medicaid program to cover mental health and substance use services for youth with significant mental health conditions. CMS staff are available to states to further discuss how they can use the authorities below to promote better coverage.

1905(a) Authority
Many of the services that were core to the success of the CMHI and PRTF Demonstration program can be covered through 1905(a) authority, generally through targeted case management or rehabilitative services. States that have used the 1905(a) authority as a foundation for their benefit design for children and youth with significant mental health conditions include: Massachusetts, Connecticut, New Mexico and Hawaii. More information about some of these states can be found at:

- http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/ (Massachusetts)
- http://www.bhc.state.nm.us/BHServices/ServiceDefinition.html (New Mexico)

1915(c) Authority
Some states have used the 1915(c) Home and Community-Based Services (HCBS) program to develop good benefit designs for children and youth with significant mental health conditions. The nine states that participated in the PRTF five-year demonstration grants utilized the 1915(c) waiver authority. These states included: Alaska, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina and Virginia. Eight other states also use the 1915(c) authority for these children and youth. These states include: New York, Michigan, Wisconsin, Louisiana, Texas, Iowa, Kansas, and Wyoming. States have used these HCBS waivers to expand their array of home and community-based services and supports for this population with a view towards improving outcomes and reducing costs. Below are links to some states' 1915(c) HCBS Waivers for children and youth with significant mental health conditions: https://myshare.in.gov/FSSA/dmha/caprtf/PRTF%20Transition%20Waiver/1915c%20PRTF%20Transition%20Waiver_CMS%20Application.pdf. For more information about 1915(c) Home and Community Based Waivers, please access Medicaid.gov: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html

1915(b) Authority
1915(b) Waivers are one of several options available to states that allow the use of managed care in the Medicaid Program. When using the 1915(b) authority, states have various options for implementing managed care including the authority to restrict the types of providers that people can use to access Medicaid benefits and the ability to use the savings to the state from a managed care delivery system to provide additional services or restrict the number or type of providers who can provide specific Medicaid services. Louisiana, Michigan, Iowa and California are examples of states that have used the 1915(b) authority (and sometimes a combination of 1915(b) and 1915(c) and other authorities) for their children's mental health delivery systems. More information regarding their managed care approaches for these delivery systems can be found at:

- http://new.dhh.louisiana.gov/index.cfm/page/538 (Louisiana)
- http://www.ime.state.ia.us/Reports_Publications/RFP/IowaPlan.html (Iowa)
- http://www.michigan.gov/documents/mdch/Managed_Speciality_Services_and_Supports_Waiver_364598_7.pdf (Michigan)

1115 Authorities
Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that further the objectives of the Medicaid and the Children's Health Insurance Program (CHIP). These demonstrations give states additional flexibility to design and improve their programs, to demonstrate and evaluate policy approaches, such as providing services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. Many section 1115 demonstrations include mental health services for children and youth. Most recently, Arizona received approval for a section 1115 demonstration that integrates physical and behavioral health services provided to children enrolled in the Children's Rehabilitative Services program. More information on this section 1115 demonstration can be found at: http://www.azahcccs.gov/reporting/federal/waiver.aspx.

1915(i) State Plan Amendment
Section 1915(i) state plan amendment (SPA) provides an opportunity for states to amend their state Medicaid plans to offer intensive home and community-based behavioral health services that were previously provided primarily through 1915(c) HCBS waivers programs. Intensive care coordination, respite, parent and youth support partners, and other services can be offered under 1915(i) and serve children and youth with significant mental health conditions. Under 1915(i) states may not waive the requirement to provide services statewide, nor can they limit the number of participants in the state who may receive the services if they meet the population definition. Unlike the 1915(c) waiver program, the 1915(i) delinks the provision of services with participants meeting an institutional level of care. In order to target the initiative and limit costs, states may identify a specific population and establish additional needs-based criteria. For example, a state could develop need-based criteria only for children and youth at risk of removal from their homes or in need of intensive community-based services and behavioral interventions in their homes, schools, or communities to control aggressive behavior towards self and others. An example of a state with approved 1915(i) SPAs for children and youth with significant mental health conditions is:

- http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf (Montana)

For more information about the 1915(i) SPA and beneficiary eligibility please access Medicaid.gov: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html.

Section 2703 Health Homes
Health homes (Affordable Care Act-Section 2703) are a Medicaid state plan option available for states to design programs to better serve persons with chronic conditions, including serious and persistent mental health conditions. Health homes must provide for an individual's primary care and disability-specific service needs, and must provide care management and coordination for all of the services needed by each enrolled individual. The major goal is to provide more comprehensive, coordinated, and cost-effective care for individuals with chronic conditions, including children and youth with serious emotional disturbances, than generally provided when services are fragmented across multiple health providers and organizations.

Federal match of 90 percent is available for 2 years for the following services provided through the health home authority: comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings including appropriate follow-up care, individual and family support, referral to community and support services, and the use of health information technology to link services. The health home state plan optional benefit under section 1945 of the Social Security Act is statutorily-defined as services for "eligible individuals with chronic conditions" and does not allow for coverage to be limited to a subcategory of individuals. However, CMS recognizes that the service needs of individuals within a population may vary, and therefore that the treatment modalities, protocols and provider network may involve different approaches for children as compared to adults for key health home activities such as coordinating, managing and monitoring services. States may develop different approaches that serve different age groups, based on distinctions between the health home needs of the population. Therefore, CMS will allow states to submit separate SPAs for children and youth with serious and persistent mental health conditions as long as another SPA for adults with serious and persistent mental health condition is submitted simultaneously.

States that have health homes SPAs specifically for individuals (including children and youth) with these conditions include Missouri, New York, and Ohio. Information on these approved state plans can be found at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html. For more information about health homes, go to Medicaid.gov: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html.

Money Follows the Person Rebalancing Demonstration (MFP)
MFP provides an opportunity for states to offer community based services and supports to individuals transitioning from qualifying institutions to qualifying home and community based settings, including children and youth 21 years of age and under who have been in PRTFs or psychiatric hospitals for at least 90 consecutive days and are transitioning to community settings, including family homes, foster homes, alternative family-based homes, or other community-based settings. MFP allows an enhanced federal match equal to an additional 50 percent of the state share with an upper limit of 90 percent. The enhanced federal match on qualified Medicaid services is available for 365 days after each individual's discharge from the institution. The state may also provide additional supplemental transition services to support the youth to successfully move into the community, including but not limited to household set-up, home modifications, or peer support. States are required to have the ability to meet the needs of the children and youth after the 365-day period.

The MFP is a good vehicle for states to transition youth from PRTFs to the community, particularly because the average length for youth needing intensive community based services after discharge in the PRTF demonstration was consistently close to the 365 days – the allowable service duration of enhanced match under MFP. If the children and youth continue to need services and supports after 365 days in the community, services covered under other Medicaid authorities discussed above may be provided to address their needs.

For more information about MFP, go to Medicaid.gov: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html

Balancing Incentive Program

The Balancing Incentive Program, created by the Affordable Care Act (Section 10202), authorizes grants to states to increase access to non-institutional, long-term services and supports (LTSS) and was effective as of October 1, 2011. The Balancing Incentive Program can help states transform their long-term care service systems by lowering costs through improved systems performance and efficiency, creating tools to help consumers with care planning and assessment and improving quality measurement and oversight. Enhanced federal match is available to states for 4 years. To participate in the Balancing Incentive Program, a state must have spent less than 50 percent of total Medicaid medical assistance expenditures on non-institutionally based LTSS for fiscal year 2009. The Balancing Incentive Program also provides new ways to serve more people in home and community-based settings, helping states comply with their obligations under the integration mandate of the ADA, as interpreted by the *Olmstead* decision. Most states that have approved applications under this program include mental health services in their rebalancing efforts. More information regarding this program can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html.

Quality Reporting

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and the Affordable Care Act all introduced new clinical quality reporting programs that apply to Medicaid and CHIP providers. These clinical quality reporting programs add to existing Medicare quality reporting programs, as well as measure sets that may be used by state Medicaid programs and private plans, such as the Healthcare Effectiveness Data and Information Set (HEDIS) measures. Several core measure sets have now been identified, which include a number of measures related to hospital readmission rates for children and youth with mental health and substance use conditions.

Some specific reporting measures that states may consider in their approach to their tracking efforts are listed below. Please note that the quality measures and measure sets noted below are not exhaustive and will continue to evolve.

Follow-up after hospitalization for mental illness among patient 6 years and older (NQF #576). Applicable measure sets include:

- CHIPRA Core Set of Pediatric Quality Measures
- Initial Core set of Health Care Quality Measures for Medicaid- Eligible Adults
- Health Home Core Set

- Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (NQF #1365). Applicable measure sets include:
  - HITECH Act: Meaningful Use of Electronic Health Records

In addition to these measures, the CMHI and PRTF demonstration program collected specific measures that providers were required to provide as a condition of participation in these programs. These measures consisted of a set of process measures that were related to the goals of the program, especially regarding safety. There are other resources states may consider for developing specific outcomes for children and youth with significant mental health conditions, including:

- Child and Adolescent Functional Assessment Scale (CAFAS) - http://www.fasoutcomes.com/Content.aspx?ContentID=12
- Child and Adolescent Needs and Strengths (CANS) – https://dmha.fssa.in.gov/DARMHA/Documents/IN%20Short%20CANS%20Form%205-17_712011_Manual.pdf