

Using Home-Based Programs in Other States to Support a Medicaid Claim to Intensive Home-Based Services Under EPSDT

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I. Introduction

Because EPSDT requires states to provide medically necessary treatment for children, and specifically intensive home-based services for children with serious emotional disturbance¹ effective programs in other states can be used to support a Medicaid claim that these services must be offered in other states.

There are two basic requirements for Medicaid coverage: (1) the service must be a form of medical assistance listed in the statute, 42 U.S.C. § 1396a(d); and (2) the service must be medically necessary. Evidence of what other states offer as part of their EPSDT benefit, and for which they claim federal financial participation (FFP) under the Medicaid program, can be convincing evidence that that service is a form of medical assistance, and thus a covered treatment under Medicaid. While states define medically necessity somewhat differently, positive treatment outcomes for children and data demonstrating effectiveness in treating or ameliorating mental health conditions are similarly convincing evidence that the service should be offered in other states.

II. Selected Examples of Effective Home-based Services

A number of states have created home-based services, either as part of a statewide initiative, regional pilot program, or local demonstration. This QA describes in some detail four examples of effective home-based programs. A listing of all states that offer some form of home-based services, current as of 1999, can be found in Koyanagi, Making Sense of Medicaid (Bazon Center for Mental Health Law 1999). A more detailed description of the services offered and funded in selected states is attached as Appendix A.²

A. Wraparound Milwaukee

The President's New Freedom Commission on Mental Health Subcommittee on Children and Family cited Wraparound Milwaukee as an exemplary program in children's mental health and in the delivery of comprehensive and individualized care to children with serious mental health needs.

¹ See Using Medicaid to Obtain Intensive Home-Based Services for Children with Serious Emotional Disturbance, September QA from the Center for Public Representation, available on NDRN's website.

² The chart in the Appendix was prepared by a Massachusetts Medicaid official. It is attached as a separate pdf document that can be enlarged to 200% to be more readable.

Established by the Milwaukee County Health and Human Services Department in 1995 to address the rising number of children being placed in psychiatric hospitals and residential treatment facilities, Wraparound Milwaukee created comprehensive home and community-based alternatives for children with serious emotional disturbance. The program, which served 847 families in 2003 and received over \$30 million in funding from Medicaid, mental health, child welfare, and juvenile justice, has been responsible for reducing residential treatment placements in Milwaukee County from a daily average of 375 placements to approximately 70 placements and for reducing the use of psychiatric inpatient care from several thousand days of care to under 300 per year for SED youth. Although Wraparound Milwaukee benefits from the additional funding and support of non-Medicaid resources, many of the home-based supports it offers and outcomes it achieved, can be and have been replicated in other states through programs developed primarily with Medicaid resources and covered services.

Wraparound Milwaukee is an example of a home-based services program. The program operates on a philosophy that emphasizes individualizing care, building on the strengths of a child, meeting the needs of children and families across life domains, involving families as full and active partners in all treatment decisions. Wraparound Milwaukee utilizes a team-driven process involving the family, child, natural supports, clinical provider agencies and other supports to develop, implement and evaluate the care plan. In fact, the Wisconsin Medicaid agency authorizes this integrated, coordinated team to make decisions related to the medical necessity of services for the enrolled child.

In Wraparound Milwaukee, a care coordinator/case manager facilitates the team process, helps the family identify strengths and needs and helps obtain services the integrated planning team identifies. The team and case management functions are critical to the success of the program, both by ensuring that needed services are provided and by ensuring that all distinct services and providers are integrated into a coordinated service approach. Instead of a single service, Wraparound Milwaukee care coordinators can directly access over 80 different covered services including individual and family therapy, substance abuse, in-home therapy and behavior management specialists, crisis stabilization workers as well as other covered services such as mentors, tutors, job specialists, transportation, and day treatment.

Wraparound Milwaukee also provides a 24-hour mobile crisis team that can intervene at the child's home, at school, or wherever the child resides if he or she has a mental health crisis that threatens the child being removed from a community placement.

Besides significantly reducing the numbers of residential treatment, psychiatric hospital and correctional placements, clinical outcomes of enrolled youth have improved based on nationally accepted evaluation instruments. In addition, the school attendance of enrolled youth has increased. Similarly, there has been a significant decrease in recidivism rates of delinquent youth from prior to enrollment in Wraparound Milwaukee to one and three years following disenrollment (average enrollment period is 18 months).

B. Massachusetts' MHSPY Program

The Massachusetts MHSPY program is the best example of home-based services in the state. It integrates behavioral and physical care for children with serious emotional disturbance. It targets children at risk of out-of-home placement or those in an out-of-home placement determined to be ready for return to the community or a transitional type placement. Length of stay can exceed a year or more depending on need. Case managers have direct access to all behavioral health services for children. This means any child in MHSPY gets the full coverage of their medical services, including medication, hospitalization and all the standard Medicaid benefits. In addition, they get all the standard mental health and substance abuse coverage.

The MHSPY program employs a wraparound, individualized, needs-based planning process that is fundamental to meeting providing home-based services. It can arrange and pay for non-traditional services and supports, such as respite care for families, a tutor, a parent aide, transportation, a mentor, etc. It has great flexibility due to the blended funding in the model. It is co-funded by multiple state departments (the Office of Medicaid and the Departments of Education, Mental Health, Social Services and Youth Services), as well as by local school districts. However, as a result of recent cap rate review by state Medicaid office and the federal government, the vast majority of its services and costs are covered by Medicaid.

The average cost for enrollees between October 27, 1999 and September 31, 2001 of \$3,300 per person per month was about one-third of what the average child living out-of-home in Massachusetts cost for placement alone. A recent fiscal analysis of current costs indicated that when all medical and behavioral services, including medication, hospitalization, and all other necessary treatment are combined together, the total cost is approximately \$4,500 per person per month, most of which (\$4,200 per month) was for Medicaid-covered services.

C. Rhode Island's Community-Based Intensive Services

Home-based behavioral services also have enabled Rhode Island children at risk of out-of-home placement to make progress, improve functioning, and continue to live in their communities with their families or foster families.

Through a program known as Community-Based Intensive Services (CIS), community and home-based services are provided by bachelor's and master's level clinicians, and may be offered up to 20 hours a week based on acuteness and intensity of need, consistent with medical necessity. Children receiving these services typically remain with their families, though these services may also be provided to children in residential care. These services are offered for a period of six months and may be renewed repeatedly based on need. The services are coordinated by a case manager and prescribed, delivered, and monitored by a team that includes the family member, relevant providers and professionals, and the case manager. The specific interventions provided

by this program, either directly or in affiliation with another provider, include comprehensive assessments, mobile crisis intervention, case management, behavior therapy or specialists, medication, counseling and other clinical therapies as needed. All of these services are funded by Medicaid.

If it appears that a child warrants more intensive services than traditional outpatient treatment, the assessing clinician completes two rating scales, the Modified Children's Global Assessment Scale (MCGAS) and the Ohio Mental Health Consumer Outcomes System Youth Problem, Functioning, and Satisfaction Scales (OHIO). In addition, within the first month of treatment, a Child and Adolescent Functional Assessment Scale (CAFAS) is completed. This scale also is used as an outcome measure at various times during treatment. The rating scales and reviews result in acuity determinations, which guide the intensity of service. All clients must be at risk of hospitalization or placement out of the home in order to be eligible for CIS services.

Each child's treatment and plan are reviewed at least monthly by a multidisciplinary team comprised of the case manager, a masters level therapist, the child and family member, and the psychiatrist. All cases are subject to periodic Medicaid review by the state agency, the Department of Children, Youth & Families.

CIS services include intensive case management, home and community-based individual and family counseling, including behavior management training of primary caretakers in the home and community. In addition, 24-hour-a-day emergency service backup including a child trained clinician and a psychiatrist on call is available as needed. Acute situations may also be addressed in the context of a partial or "day" hospital setting. Typically, the therapist models appropriate behavior management interventions for the primary caretaker or coaches them during situations as they occur in the home while the worker is present. Child psychiatric services are office-based.

Children and adolescents who require long-term community/home-based services or who require ongoing support for greater than 20 hours per week are referred to other community agencies with home-based treatment services designed to meet these needs. These services include comprehensive assessments, mobile crisis intervention, case management, behavior therapy or specialists, medication, counseling and other clinical therapies as needed, and can offer any or all of these interventions with greater intensity and frequency than our program. All of these services are funded by Medicaid.

Home-Based Therapeutic Services

When CIS level intensity interventions are not adequate or comprehensive enough to meet the needs of clients and families, or the need for intensive services is identified as longer term and chronic, the child is referred for assessment to one of four Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) centers across the state. The centers provide information for families about available services, perform comprehensive evaluations of children with special needs, make treatment recommendations, coordinate care, and provide ongoing re-assessment

and treatment reviews. A CEDARR evaluation may result in referral to a Home-Based Therapeutic Services (HBTS) program. There are approximately 14 HBTS providers in Rhode Island. The only access to HBTS services is through a CEDARR center. This process evolved from Rhode Island's EPSDT program, in which primary care providers could prescribe Medicaid-funded therapeutic services for their patients. The establishment of CEDARR centers and HBTS programs was designed to provide utilization review and standardization in the provision of these services.

HBTS services were designed and initiated by Christine Ferguson, the former commissioner of the Department of Children and Families in Rhode Island and the former public health commissioner in Massachusetts. The services are now widely used by Medicaid-eligible children in Rhode Island and have allowed many children to continue to live in their family settings rather than being acutely hospitalized or placed in residential treatment settings. In the family and community context in which their problems occurred, more effective interventions have met with greater success than residential settings, which disrupt families and decrease learning. Children in substitute care in Rhode Island have been able to return from out-of-state placements to local, less restrictive settings where they were able to reintegrate into their own families and communities. These children experienced a reduction in inpatient psychiatric treatment days compared with the period preceding the availability of an intensive community-based treatment program.

D. Pennsylvania's Behavioral Rehabilitative and Therapeutic services

Pennsylvania lacked adequate home-based, community-based, and school-based behavioral rehabilitative and therapeutic services to address the behavioral health needs of severely emotionally disturbed children and adolescents prior to a 1991 EPSDT lawsuit (*Larry K. v. Snider*). Despite a clear need for such services to support the severely emotionally disturbed child and family at home, physicians, psychologists, and other behavioral health professionals did not prescribe or recommend them due to the absence of commercial or Medicaid billing codes or reimbursement mechanisms for home-based, community-based, and school-based professional mental health services.

As a result of the settlement stemming from the *Larry K.* lawsuit, Pennsylvania established a process for requesting and receiving reimbursement for home-based, school-based, and community-based behavioral services from Medicaid through a case-by-case application process. While this development was positive, the complexity and difficulty of requesting and creating home-based, community-based, and school-based professional mental health services on a child-by-child basis through the individual application process discouraged many clinicians from recommending them, despite the significant number of children who needed them.

Subsequently, the Pennsylvania Medicaid agency created a fee schedule that allowed for several of the most frequently requested services – mobile therapy, therapeutic staff support, and behavioral specialist consultants. This provided an incentive for some practitioners and agencies to recommend or begin to provide these

services. Nonetheless, the administrative paperwork, approval requirements, and inadequate reimbursement rates for these home-based, community-based, and school-based professional mental health services created a barrier to effectively delivering the services in a timely manner to children and adolescents.

After a second EPSDT lawsuit was filed in 1999 (*Kirk T. v. Houstoun*), Pennsylvania provided detailed program descriptions, simplified administrative billing processes and quality assurance reporting requirements, raised reimbursement rates, and increased specific training and written resources to support providers who wished to provide the services. In addition, a tracking mechanism was put into place to support the timely delivery of these services.

As a result of such changes, an increased number of clinicians and agencies in Pennsylvania began to recommend and deliver these services for a significant number of children who required them. Currently, home-based, school-based, and community-based behavioral services are widely utilized in Pennsylvania, in both fee-for-service and managed Medicaid environments. These services are effective in supporting children with serious emotional disturbances and enabling them to remain in their homes and communities.

III. Conclusion

While advocates must carefully investigate whether other state programs for children are actually covered by Medicaid, in whole or in part, whether that funding is part of the state's Medicaid plan or a demonstration waiver, and whether the program is part of the EPSDT benefit, other state's Medicaid-funded home-based services can be convincing evidence of both the effectiveness and coverage of these services. This evidence should be used in any EPSDT case seeking to require similar services for children in your state.