STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

Session Law 2015-135, Section 5

Department of Health and Human Services
Division of Medical Assistance

December 1, 2015

Authorizing Authority

S.L. 2015-135 [Foster Care Family Act], Section 5

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

SECTION 5.1. (a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with Serious Emotional Disturbance to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act become effective October 1, 2015.

Introduction

In Session Law 2015-135 [Foster Care Family Act], Section 5, the General Assembly authorized the Division of Medical Assistance to study the feasibility of implementing a 1915(c) Home and Community-based Medicaid Waiver for Children with Serious Emotional Disturbance (SED), and to submit a report on the findings and a draft waiver by December 1, 2015. A 1915(c) waiver for children and adolescents with SED would allow children who meet the level of care for placement in a psychiatric residential treatment facility (PRTF) and their families to have a choice of receiving Home and Community-based Services (HCBS) in their home or foster home in the community rather than being placed in a restrictive institutional setting. Currently, children and adolescents in and out of foster care who have a serious emotional disturbance and meet medical necessity for admission to a PRTF or psychiatric hospital level of care, are placed in an institution. These children and families do not have the choice of receiving services in their homes or foster homes in the community, rather than in institutions.

This draft waiver was included in the Foster Care Family Act because of the urgent need in North Carolina for access to home and community-based waiver services for children served by the foster care program (foster care children are automatically eligible for Medicaid). Many of these children and adolescents experience serious emotional disturbance resulting from the abuse and neglect they have been exposed to and the impact of that traumatic exposure. This is often exacerbated, once in the system, by multiple disrupted placements. HCBS would also be available to other Medicaid eligible children and adolescents who require treatment and interventions for serious emotional disturbance.
This report includes the following:

- Background information on 1915(c) Medicaid waivers;
- The findings of the CMS sponsored 1915(c) PRTF Demonstration Waiver Program; Outcomes from other states that have developed these services;
- Demographic information about the target populations for this waiver and the need for waiver services in North Carolina (NC);
- Proposed cost and utilization data ; and
- Recommendations for consideration by the Joint Legislative Oversight Committee on Health and Human Services.

1915(c) Medicaid Waivers

Under the authority of Section 1915(c) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) grants waivers that allow states to design alternative, home and community-based services for individuals who, without these waiver services, would require placement in one of the following types of institutions:

- Skilled Nursing Home
- Intermediate Care Facility
- Hospital, including Inpatient Psychiatric Services for individuals under 21, the PRTF benefit, delivered in licensed hospitals

To be eligible to receive 1915(c) waiver program HCBS and supports, individuals must be assessed as meeting the criteria for admission into the institutional level of care. Under the 1915(c) authority:

- States are allowed to design and cover a wide range of habilitative services, i.e., services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These services are otherwise not available under the State Medicaid Plan.
- The services must be budget neutral, i.e., the annual per person cost of the waiver services may not exceed the per person cost of placement in an institution.

- States may waive State Medicaid Plan requirements for state wideness which allows for phased in implementation or operating the waiver only in selected geographic areas of a state.
- States may also be approved to waive comparability of services, which permits states to offer additional services to the approved target population that are not available to all Medicaid beneficiaries.
- States may establish ceilings on the number of persons who can be enrolled in the program. That is distinct from the unlimited enrollment of all individuals who qualify for the regular Medicaid program.

In the waiver application, states must assure CMS that certain safeguards are in place including:

- Development of the waiver with stakeholder input;
- Parental or caregiver choice of waiver services or placement in an institution;
- A family directed person centered planning process;
- Choice of providers;
- A quality assurance program;
- Appeals process; and
- Program evaluation.

A 1915(c) waiver may also be operated or combined with a Section 1915(b) waiver, which allows limits on a beneficiary's choice of providers to those providers selected for inclusion in a managed care network rather than allowing for any willing provider to serve the plan's members. The managed care plan's limited network must meet access standards to assure that covered state plan services are accessible and available to plan members. This combination of waivers becomes a 1915(b)(c) waiver, under which North Carolina is currently operating its behavioral health services managed care plans. Therefore, the waiver of beneficiary choice is also currently operationalized for enrollees in North Carolina's approved 1915(c) waiver for persons with Intellectual and Developmental Disabilities. As North Carolina moves toward Medicaid reform over the next several years under the authority of an 1115 Demonstration Waiver, distinguished by its effect of allowing waivers for multiple other Medicaid State Plan requirements for experimental, pilot or demonstration projects designed to assist in promoting the objectives of Medicaid law and the intent of the Medicaid program, federal regulations allow a 1915(c) waiver to operate in combination with an 1115 waiver. CMS has approved this combination in Kansas.[1]

North Carolina operates three approved 1915(c) waivers that provide HCBS to children with complex medical issues, children and adults with intellectual and developmental disabilities, and aged and disabled adults. Medicaid beneficiaries enrolled in these waivers are not placed in institutions; they receive HCBS services that allow them to remain in their homes and communities. Waiver enrollees maintain access to all other Medicaid services covered under the State Plan.

PRTF Demonstration Waiver and Evaluation

Prior to 2005, only eight states were providing HCBS under a 1915(c) waiver to children with serious emotional disturbance, due to certain restrictions related to the use of PRTF expenditures for a 1915(c) waiver, even in light of the benefits of community-based services for other target populations. In order to test the cost-effectiveness of providing services in a child's home or community rather than in a restrictive and costly PRTF, and to determine whether services improve or maintain the child's functioning, the Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Program was authorized by Section 6063 of the Deficit Reduction Act of 2005. Nine states (Alaska, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina and Virginia) were awarded grants to implement these services and served over 5,300 children during the five years of the Demonstration Programs.

An independent evaluation of the PRTF Demonstration Programs released in May 2012 showed that it succeeded in maintaining or improving children's functional outcomes.[2] The findings of the evaluation were based on data collected in five domains: mental health, juvenile justice, school functioning, alcohol and other drug use and social supports. While findings varied by domain, most children showed improvement. Analysis of the data demonstrated that the PRTF waiver programs yielded the following behavioral and functional outcomes:

- More stable living situations;
- Reduced suicide attempts;
- Improved attendance at work for caregivers;
- Decreased contacts with law enforcement;
- Reduced costs of care;
- Improved school attendance and performance;
- Increase in behavioral and emotional strengths;
- Improved clinical and functional outcomes; and
- High satisfaction among participants, both children and their families.

Of significant note was the common finding that children and adolescents assessed as having a higher level of need at baseline benefited the most from receiving these services.[3] They are the same children that are most likely to have the longest PRTF stays.

Another federal project that focused on shifting children from institutional placements to home- and community-based placements was the Substance Abuse and Mental Health Services Administration's Children's Mental Health Initiative. This project had similar results, with children seeing improved clinical and functional outcomes, more stable living situations, decreased contact with law enforcement, and decreased suicide attempts.[4]

Along with these favorable behavioral and functional outcomes, the treatment costs associated with the demonstrations were on average far lower than institutional alternatives, with an average per capita savings of $36,500 to $40,000, or up to a savings of 68 percent.[5]

Below are outcomes data from five states' initiatives as presented by Shelia Pires and Dayana Simons in their 2014 presentation: *Customizing Medicaid Managed Care Systems for Children in Child Welfare and Children with Behavioral Health Challenges: Reduced Costs and out of Home Placements*.[6] In the outcomes data below, the term "Care Management Entity" (CME) means the agency that delivers the wraparound facilitation or intensive care coordination in the state.

Wraparound Milwaukee

- Reduction in placement disruption rate in child welfare from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily population in residential treatment centers from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days per year to <200 per year
- Average monthly cost of $4,200 (compared to $7,200 for residential treatment centers, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

New Jersey

- Savings of $30 million from 2007 to 2010 by reducing the use of acute inpatient psychiatric services
- Residential treatment budget was reduced by 15% during the same time period, and length of stay in residential treatment centers decreased by 25%

Maine

- Experienced 30% net reductions in Medicaid spending, comprised of decreases in PRTF and inpatient psychiatric services with increases in targeted case management and home and community-based services

Maryland

- Cost of serving PRTF Waiver youth in the CME is 35% of the cost of serving youth in PRTFs

Georgia

- Medicaid annual average cost for a CME youth is $44,008 less than average annual cost for PRTF youth (CME = $34,398, PRTF =$78,406)
- Comparing youth out-of-home placements in the 6 months pre-CME engagement to the 3-8 months post-CME engagement showed:
  - 86% reduction in inpatient hospitalization for CME youth meeting PRTF waiver criteria
  - 89% reduction in inpatient hospitalization for other high need youth enrolled in CME
  - 73% reduction in PRTF stays for CME youth meeting PRTF waiver criteria
  - 62% reduction in PRTF stays for other high need youth enrolled in CME

Similar findings are also supported in a White Paper on *Perspectives on Residential and Community-Based Treatment for Youth and Families* prepared by Magellan Health Services Children's Services Task Force, which concluded, "While residential treatment remains an important component of a system of care, for most youth, community-based interventions represent a more appropriate and less costly alternative to residential placement."[7]

Based on the clinical and fiscal outcomes of the demonstration projects outlined above, many states are developing programs to provide access to these services for high risk, high cost children and adolescents and their families. These services are focused on improving outcomes for children and lowering costs to the states. The most widely used funding mechanism to access Medicaid reimbursement for these services is under a 1915(c) waiver.

Wraparound Approach and Philosophy

While states have flexibility in designing home and community-based services for children with serious emotional disturbance, each state demonstrating these positive outcomes utilizes a "wraparound approach" and philosophy in the delivery of services to these high risk children. This approach is critical to successful treatment of high risk children in the community in lieu of restrictive placement in a PRTF. The wraparound approach is based on the understanding that these children and their families have complex needs and problems across many domains and are involved in many systems. The multifaceted needs of these children and families require intensive planning, coordination and implementation of services with all agencies and professionals involved with the child in order to be successful.[8]

Foremost in this approach is the importance of the family's and child's voice and choice in driving the planning and implementation of the plan. Their input is also essential in the ongoing assessment and monitoring of the service plan to make sure that the plan is effective in meeting their needs. The engagement of the family provides opportunities for improved relationships and problem solving during treatment that

will support the child and family at discharge. During the design and implementation of the wraparound plan, the wraparound facilitator works with the family and child and their team to identify and engage natural supports. The wraparound approach does not just identify and address the child's presenting problems, but identifies and builds on the child and family's strengths and talents to support ongoing growth and development.[9]

Wraparound facilitation is critical to the success of treating children in the community who are in need of PRTF services. It is the central service in an array of other home and community-based services that are essential to support children and families who choose community living over out-of-home placement. These services are available only under a waiver and are not otherwise accessible under the Medicaid State Plan. The services include respite, parent training, parent and youth peer support, flexible funds and others. These services are discussed in more detail in the 'About 1915(c) Waiver Services' section of this report.

Serving this population of youth with SED safely and effectively in the community is complex and requires a strong commitment on the part of payers and providers. It also requires a strong infrastructure and adequate funding for training, supervision, and coaching and performance evaluation. Challenges and unsuccessful treatment in this model are often traced back to the lack of fidelity and best practice elements. Research underscores the importance of careful attention to adherence to the practice, and maintaining a focus on fidelity to the model.[10]

Current NC Wraparound Initiative

In consideration of the feasibility of developing and implementing a Medicaid 1915(c) waiver for children with SED in North Carolina, it is important to note that the Division of Mental Health, Developmental Disabilities and Substance Abuse Services under the Department has recently been awarded a Substance Abuse Mental Health Services Administration (SAMHSA) System of Care (SOC) Expansion Grant. The grant funds the development and implementation of five High Fidelity Wraparound teams in five geographical areas of the state. The teams are located across four of eight Prepaid Inpatient Health Plans' (PIHPs) catchment areas: Eastpointe, CenterPoint Human Services, Cardinal Innovations Healthcare Solutions (two teams) and Smoky Mountain Center.[11] This grant funded initiative is providing a wealth of information and experience that will be indispensable for preparing for such an expansion under an approved waiver.

Proposed Waiver Target Population

The target population of the proposed waiver for North Carolina includes Medicaid eligible children, ages 6 to 21, both in foster care and in the custody of their parents or guardians, who have been assessed as having a serious emotional disturbance and who meet medical necessity criteria for admission into a PRTF.

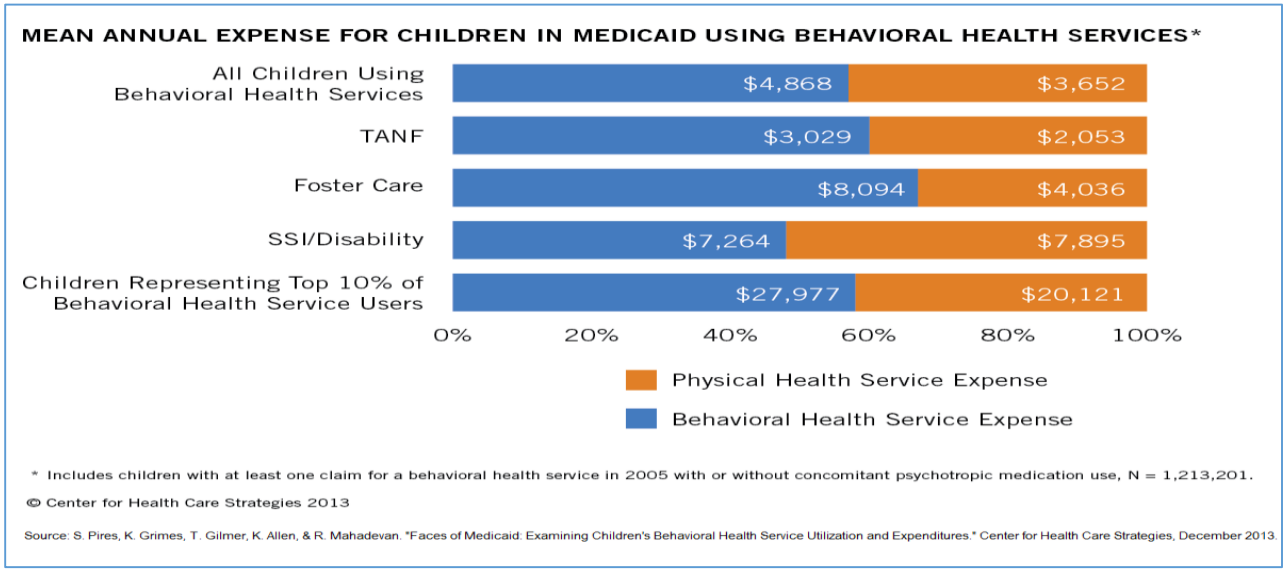
Access to these services is specifically recommended for the children and adolescents served by the foster care system.[12] Wraparound facilitation can serve children in their own home or in a foster home during treatment, with both the foster parents and the child's biological parents serving on the child's team, particularly if the goal is for reunification. This work can increase the likelihood of successful transition and reunification. Additionally these services could prevent a traumatic move to a restrictive setting and another disrupted placement, and allow a child to remain in a more normalized living setting in the community.

The elements that guide the Wraparound approach - care coordination, home and community-based services, family engagement, and continuity of care - are principles that will also support the goals of child wellbeing that states are charged with meeting for children in the foster care system. Coordinating services and treatment planning with birth parents, foster parents and/or relatives requires significant knowledge

and skill but is essential for the successful transition home when youth have significant behavioral health challenges.

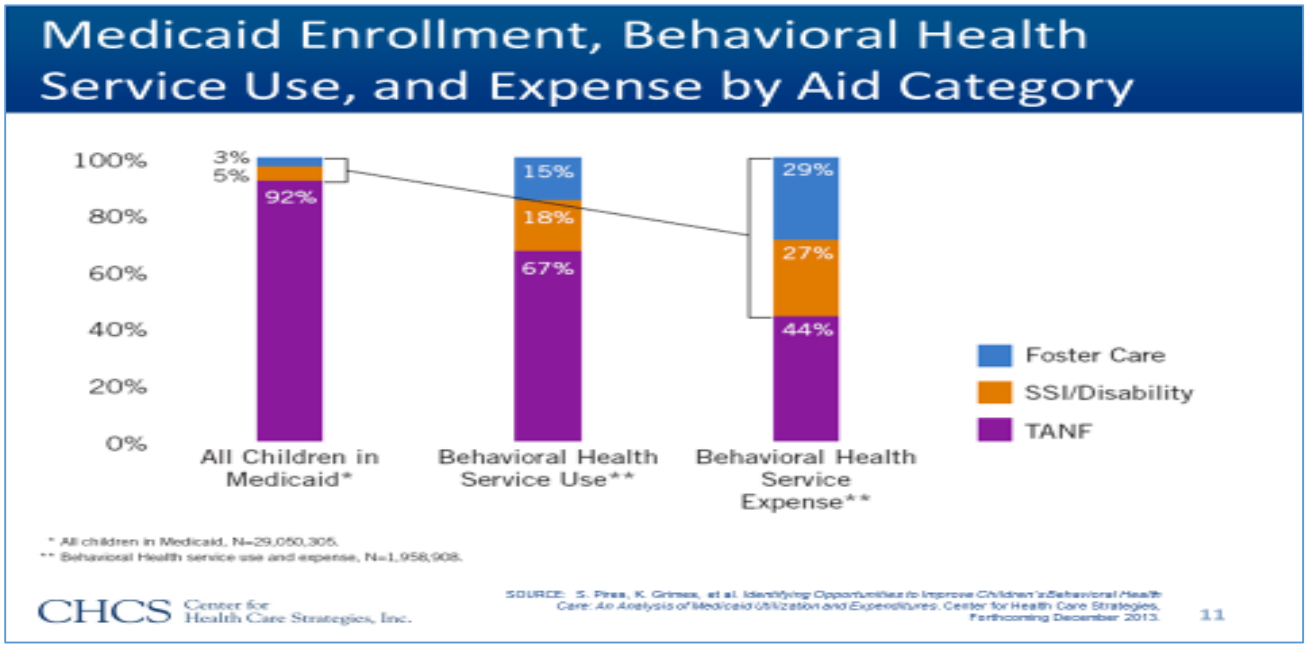
The likelihood of achieving successful outcomes such as timely reunification is greatest when all parties involved are working together on behalf of the child. These benefits to the child's well-being are accompanied by findings of cost savings to the system. As seen in **Chart 1** below, with data based on findings of a national study of fee-for-service Medicaid Utilization and Expenditures in Behavioral Health Services conducted by the Center for Health Care Strategies, Inc., children and adolescents in foster care are high utilizers of behavioral health services.[13]

Chart 1: **Annual Expenditures for Medicaid Eligible Children Using Behavioral Health Services**



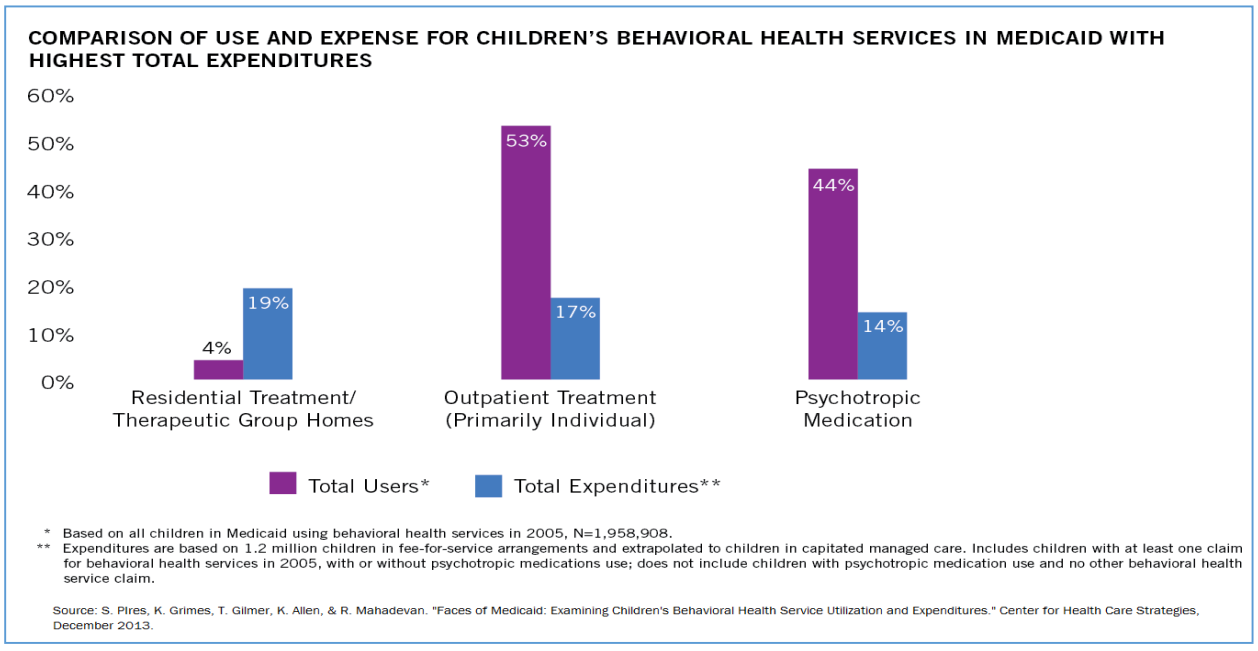
As further demonstrated in **Chart 2** below, while children in foster care represented only 3% of all children on Medicaid, these children and adolescents accounted for 15% of children using the services, and 29% of behavioral health expenditures.[14]

Chart 2: Medicaid Use and Expenditures for Services for Children, by Eligibility Group



The high cost associated with behavioral health services is driven in great measure by the high use of costly and restrictive treatment in PRTFs and therapeutic group homes. The study *Medicaid Utilization and Expenditures in Behavioral Health Services* also identified high costs associated with residential services for the general Medicaid population. As shown in **Chart 3** below, while only 4% of all Medicaid eligible children in the fee-for-service delivery system used residential services, the services accounted for 19% of expenditures.[15]

Chart 3: Expenditures Relative to Number of Users, by Medicaid Behavioral Health Service Type



PRTF Utilization and Cost Expenditures in North Carolina

Utilization and expenditures for PRTF services in North Carolina have been historically high. Based on Medicaid paid claims data from the Department's Division of Medical Assistance (DMA) Budget Office, in 2012, 1,525 Medicaid eligible children and adolescents were placed in PRTFs, for a total Medicaid expenditure of $99,487,658, exclusive of Cardinal Prepaid Inpatient Health Plan (PIHP) numbers. The most recent statewide data for 2014 shows that 1,541 Medicaid eligible children and adolescent were served with a slight reduction in total expenditures to $93,851,777. This reduction in expenditures is most likely related to tighter management of lengths of stay by the PIHPs.

Division of Mental Health September 2012 data showed that approximately 34% of the children and adolescents placed in PRTFs were in foster care. Further analysis conducted by the University of North Carolina at Chapel Hill for the Division of Social Services supported this finding. A sampling of the number of children in foster care placed in a PRTF setting in September of each year for the previous four years and the number of children and adolescents served in PRTFs based on DMA budget analysis resulted in similar figures. Analyses by the Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Social Services show that an average of 31% of youth served in a PRTF in North Carolina were in the foster care system.

This percentage appears to be increasing as outlined by point-in-time data from the month of September for each of the last five years:

Date	Percentage of Foster Care Children in a PRTF
Sept. 2008	29%
Sept. 2009	31%
Sept. 2010	32%
Sept. 2011	31%
Sept. 2012	34%

One of the primary reasons children in foster care are removed from their foster home for a PRTF placement is lack of access to support services for the child and their caregivers in the community. Their high risk, challenging behaviors are often related to symptoms of unresolved trauma resulting from abuse and/or neglect, compounded by separation from their parents, siblings, and their familiar surroundings (including school, friends, and extracurricular activities). The inability of children and families to secure appropriate supportive community-based services upon exiting a PRTF is also one of the reasons why discharges from PRTFs are often unsuccessful. This trauma is compounded when placement in an institution occurs without the child knowing of, or having, a place to go at discharge. Treatment in these situations is difficult for the child and often unsuccessful. There is little incentive for the child to work toward goals for discharge, not knowing what awaits him. Often it will be another failed placement, creating longer periods in foster care and poorer outcomes for the child, coupled with readmission to a PRTF, psychiatric hospital or high use of crisis services. There is therefore a social cost in addition to an economic cost related to institutional placement.

Access to home and community-based services provides an opportunity for a child in foster care to remain in the community with a foster family and receive support through the waiver and the other treatment services available under the State Medicaid Plan. Individualized services, developed by a wraparound team, build on the child's and involved family members' strengths and culture. A discharge plan can be created as treatment proceeds, without loss of contact with community and the significant people in the child's life.

Proposed HCBS for the North Carolina 1915(c) Waiver for Children and Adolescents with SED

States may not include in a 1915(c) waiver any service that is already available under the state's Medicaid State Plan or under the provisions or Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Federal EPSDT provisions require States to cover any service that is allowable under Section 1905(a) of the Social Security Act, even if the state has not opted to cover it in its own State Plan. Children, youth and families who choose to participate in a waiver still have full access to all of the current State Plan medical and behavioral health services, including mental health services such as outpatient therapies, therapeutic foster care, child and adolescent day treatment, and crisis services. States may include an approved 1915(b)(3) service, which is funded by managed care organizations out of their savings, to assure access to these services for waiver participants. Access may be limited to 1915(b)(3) services if allotted savings are depleted. Additionally, states have the flexibility to select the services they deem most important for beneficiaries and may develop state-specific definitions, criteria, and limits for the services, subject to CMS approval.

The selection of services for the proposed waiver was based on a review of services and utilization data included in the independent evaluation of the PRTF Demonstration Waiver as well as on review of these sites' service definitions. The service list below is consistent with a list of Core HCBS Services presented in the joint SAMHSA-CMS Joint Informational Bulletin relating to *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*.[16] The services array was supported by the participants at a broad based North Carolina Stakeholder meeting held on October 1, 2015.

Wraparound Facilitation. This service is the cornerstone service provided under a 1915(c) waiver for children with SED. When provided with fidelity to the model, it is considered to be an Evidenced Based Model.[17]

Respite Services. Respite services are provided to relieve waiver participants' primary unpaid caregivers. Services are available on an hourly or daily basis.

Consultative Clinical & Therapeutic Services by a licensed practitioner provide expert consultation, training and technical assistance in a specialty area such as psychology, psychiatry, and social work to both families and other staff members in carrying out the treatment plan.

Family Peer Support is provided by a Nationally Certified parent partner with experience as the primary caregiver for a child or youth with emotional and/or behavioral health challenges. The role of the Family Peer Support specialist is to:

- Engage, model, and coach families to actively participate in their child's services and supports;
- Link the family with informal and formal services, per the Individualized Person Centered Plan; and
- Prepare, support, and debrief families before, during, and after Child and Family Team meetings and other service planning meetings.

Youth Peer Support is provided by a specially trained young adult age 21 or over who has experience successfully navigating and transitioning from the child mental health system. The youth peer assists participants by:

- Identifying immediate and long term needs and goals;
- Linking with informal and formal services;
- Preparing, supporting, and debriefing before, during, and after service planning meetings; and
- Helping the child/youth to develop a network of information and support.

Flexible Funds are used to purchase a variety of one-time or occasional goods and/or services needed when no other funding source is available and when the service or item is directly described in the child's plan and related to a treatment goal.

Parent Training and Counseling is provided to increase family members' ability to provide a safe and supportive environment in the home and community and to assist the family in gaining knowledge and skills necessary to understand and address specific needs of the participant.

Community Transition is a one-time set-up expense for beneficiaries ages 17 to 21 to facilitate their transition from a PRTF or from home into an independent living situation to a non-provider owned, private living arrangement where the participant is directly responsible for his or her own living expenses. While some children with SED and a co-occurring developmental disability might be eligible for this type of service under Money Follows the Person (MFP) funding for transitions from institutions, inclusion of the service in this waiver will broaden the eligibility for receiving assistance with startup cost for establishing a home in the community. The NC MFP program does not currently target persons whose mental illness is their sole disability.

Community Living Skills Training assists participants who are or will be transitioning to adulthood in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to be successful in domains of employment, housing, education, and community life. This service can also be provided to younger participants who are returning home or to a therapeutic foster care setting to increase the participant's independence and improve ability to stay in the community.

Analysis of Projected 1915(c) Waiver Costs

One of the primary federal requirements for operating a 1915(c) waiver is that the expenditures for waiver services must be cost neutral, i.e., the cost for a single beneficiary under the waiver may not exceed the average cost of a single child's treatment in the institution. As noted in the research findings, the experience across states has been that utilization of community services under a waiver have resulted in savings of 40% to 68% from the comparable cost of serving a child in a PRTF.[18]

To develop the costs analysis for a new waiver, states may base their prospective average costs and service utilization per child on the costs and utilization of other 1915(c) waivers within the state and those demonstrated by other states already operating 1915(c) waivers for the same or a similar population. The costs reported below were developed using both of these resource options.

The aforementioned service array was chosen based on a review of findings of the states participating in the PRTF Demonstration Waiver with a focus on the most often chosen, utilized and valued services, and on the anticipated needs of children and families in North Carolina. The experience to date of the SOC Expansion Grant teams has also informed this process.

The numbers for anticipated users per service were based on a review of the cost summaries presented in the actual approved waivers on the CMS website, as were the typical usage or average number of units per service per individual child and family.[19] Proposed reimbursement rates were based on a review of NC reimbursement rates and those in other states for comparable services by comparably qualified staff.

The Social Security Act (SSA) only authorizes states to consider the utilization costs for PRTFs that are located within a licensed hospital. The use of non-hospital PRTF costs were allowed under the Demonstration Waiver which has ended. Based on the positive outcomes of the Demonstration Programs however, there is support for expanding the list of institutions authorized in the SSA for use in developing waivers. There have been legislative proposals to Congress to this end, but the provisions have not yet been enacted. Therefore, to develop the cost per child per year for North Carolina's proposed waiver, DMA has calculated the annual cost per child for admission into a PRTF that is located in a licensed hospital. There are four such PRTF facilities in North Carolina: Whitaker PRTF in Central Regional Hospital; Strategic Behavioral Health Centers in Garner and in Leland; and Brynn Marr Hospital PRTF.

Based on data prepared by Mercer for SFY 2014, the annual average cost per child in the four hospital PTRFs is $37,806. This figure will be used in the cost neutrality analysis in the draft waiver. The proposed average cost per year represents a 35% savings over the $37,806 cost of services in the four hospital PRTFs that qualify for the development of cost-effectiveness in this draft waiver. A greater actual savings is anticipated when comparing per-child per-year cost of waiver services to the statewide average of costs per-child per-year for all PRTF services funded by Medicaid. According to a data report developed by Mercer Government Human Service Consultants in April 2015, based on expenditures by PIHPs for PRTF services in SFY 2014, the total expenditure for PRTFs was $93,851,777 for a total of 1541 unduplicated children. Using these cost figures for all enrolled PRTFs statewide, not limited to the four hospital based PRTFs allow by CMS, the average annual cost per child was $60,903. This amount is more in line with other states' costs and would greatly increase anticipated savings under the waiver if nonhospital PRTFs could be used under CMS regulations.

Proposed Number of Waiver Slots

The number of children served in the first year of the waiver was calculated based on the capacity for delivering High Fidelity Wraparound in the four PIHP areas that have established Wraparound Teams under the SOC Expansion Grant. This waiver, if approved, could sustain the services currently funded under the grant. Each Wraparound team will have 10 members. With an average length of stay on the waiver of 9 months or 270 days, each team can serve up to 12 children during each year.

Chart 4 below displays implementation of the waiver over the three year period allowed by CMS for any new 1915(c) waiver. Prior to the end of year three, DMA must submit a waiver renewal application, which may be approved by CMS for up to 5 additional years. Addition of new slots will be considered at that time.

In year 1, Medicaid funding for HBCS for this population would allow the capacity to increase by one team or ten slots in each area, to serve up to 180 participants. The implementation of teams is based on adding one team to the 5 PIHP sites under the grant in PIHP areas currently operating teams, and on the startup of new teams in the remaining 4 PIHP teams that do not currently have teams under the grant. Under the SOC Grant, one PIHP has two sites resulting in 5 existing teams instead of 4.

In Year 2, through the development of one team in each of the remaining four PIHP areas not currently providing Wraparound under the SOC expansion grant, the number of slots will increase to 190 and children served will be increased by another 48 to a total of 228.

In Year 3, the remaining four LME/MOC areas can create two additional teams each, to add another 120 slots to bring the total number of slots up to 270, and the total number of children served to 324.

Chart 4: **Proposed Number of SED Waiver Slots**

Waiver Years	**# Participating PIHPs**		**Teams**	**Waiver Slots**			**Children Served**		
	# PIHP Per Implementation Group		**# Teams**	**# Slots Per Team Per year**	**# Total Slots per Imple-mentation Group**	**# Total Slots per Year**	**# Total Child-ren Served Per team**	**# Total Child-ren Per year**	**# Total Child-ren Per year**
	PIHPs with SOC Grant Teams	Addition-al PIHPs w/Teams							
Year 1 Waiver	4		15	10	150		12	180	
Total # Year 1 Children									**180**
Total # Year 1 Slots						**150**			
Year 2 Waiver: Current PIHPs w/ teams	4		15	10	150		12	180	
Year 2 Waiver: Teams implemented by additional PIHPs		4	4	10	40		12	48	
Total # Year 2 Children									**228**
Total # Year 2 Slots						**190**			
Year 3 Waiver: current PIHPs w/ teams	4		15	10	150		12	180	
Year 3 Waiver: Teams implemented by additional PIHPs		4	12	10	120		12	144	
Total # Year 3 Children									**324**
Total # Year 3 Slots						**270**			

S.L. 2015-135, Section 5 requested information on the number of children who would be enrolled in the waiver as a step down from a PRTF placement and those who would be diverted. It is estimated that approximately 60% of children will be diverted from PRTF placement and that 40% will be stepped down.

Chart 5 below presents the estimated cost for waiver services for each year based on average estimated cost per child. This cost per child is based on calculations for the proposed services, cost of services, and anticipated utilization of a child for the estimated average length of stay of 9 months (See **Table 1**).

The proposed service utilization as presented in Table 1 are based on utilization data from the Demonstration Programs and anticipated usage in North Carolina. They will be subject to careful consideration and presented to stakeholders if approval is granted to proceed with this waiver. The cost basis data will not be amended, but the Division of Medical Assistance is interested in developing utilization mechanisms to control use and expenditures within cost neutrality parameters, while at the same time providing adequate choice for individual children and families as to which services are best suited to a child and family's needs while staying within allowable expenditures.

Chart 5: Projected Cost of Waiver Services

	SFY2017*	**SFY2018**	**SFY2019**
Beneficiaries	180	228	324
Average Annual Cost per beneficiary	**$24,386.24**	**$24,381.65**	**$24,385.00**
Total Costs	$4,389,523.	$5,559,016	$7,900,738
Federal Share	$2,907,620.	$3,682,345	$5,233,450
State Appropriation **	$1481903.	$1,876,751	$2,667,290
FMAP**	0.6624	0.6624	0.6624

**Costs may fluctuate in SFY 2017 depending on CMS approval and subsequent waiver implementation date.*
***Federal Medical Assistance Percentage is 100% for Indian Health services if Eastern Band of Cherokee Indian (EBCI) tribal members, who have historically required placement in a PRTF, receive Medicaid services.*

Table 1. Basis for Projected Cost per Child for SED Waiver Services for Year 1 (180 Participants)

Waiver Service/ Component	Capit-ation*	Unit	# Antici-pated Users	Avg. Units Per User	Avg. Cost/ Unit	Est. Component Cost
In Home Respite	☑	15 minutes	117	416.00	4.54	220970.88
Out of Home Respite	☑	day	27	12.00	180.00	58320.00
Wraparound Facilitation	☑	month	180	12.00	968.00	2090880.00
Assistive Technology	☑	1	4	1.00	500.00	2000.00
Community Transition	☑	1	4	1.00	1500.00	6000.00
Home and Community Living Skills	☑	15 minutes	72	410.00	15.31	451951.20
Individual Goods and Services/Flex Funds	☑	Event	72	1.00	1200.00	86400.00
Parent Peer Support	☑	15 minutes	120	480.00	15.31	881856.00
Parent Training and Counseling	☑	15 minutes	72	208.00	20.00	299520.00
Specialized Consultation	☑	15 minutes	72	90.00	31.06	201268.80
Youth Peer Support	☑	15 minutes	36	216.00	11.62	90357.12

GRAND TOTAL:	$4389524.00
Total: Estimated Cost of Services:	$4389524.00
Total Estimated Unduplicated Participants:	180
Factor D (Divide total by number of participants):	$24,386.00
Average Length of Stay on the Waiver:	270

*Will be capitated under this waiver

Chart 6 presents anticipated administrative cost for this waiver in Department and in the PIHPs, which will be under contract to implement the services in their respective areas. There is also a need for two positions within DMA for managing the waiver and monitoring compliance with CMS requirements and to ensure that expenditures are within the cost neutrality parameters. Each PIHP will require at least one additional .5 FTE position each for network management to secure providers for the new services, increased utilization management activities and ongoing enrollment, and credentialing and monitoring of new providers.

Administrative funds will also be required for training and coaching teams in the provision of High Fidelity Wraparound. Treatment failures in this model are most typically associated with lack of adherence to the practice standards and drift from the model. The experience in the Demonstration Waiver as well as the other 1915(c) non-demonstration waivers for children with SED had similar outcomes in situations where staff were not adequately trained, coached and supervised.

Funding has also been included to support the use of national, standardized clinical assessment tools and automated on line administration, database and analysis functions for measuring clinical outcomes. The Child and Adolescent Functional Assessment Tool was used by several demonstration sites. It will allow the outcomes in North Carolina to be measured against other states' outcomes. It has also been determined to be the most sensitive of the assessment tools to measure progress at admission, mid-point in treatment, and at discharge.

The additional administrative cost will be to add this proposed waiver, to the contract with the External Quality Review (EQRO) provider for ongoing evaluation and readiness reviews as new areas are added to the waiver.

Chart 6: Projected Department Administrative Costs for Proposed Waiver

	SFY2017	**SFY2018**	**SFY2019**
Total Costs (6 Staff)*	**$512,610**	**$512,610**	**$512,610**
Federal Share	$256,305	$256,305	$256,305
State Appropriation	$256,305	$256,305	$256,305
Training for New Teams	$67,027	$53,622	$53,622
Use of Standardized Assessment and Data Base for Tracking Performance Outcomes	$3,060	$3,456	$4,356
Waiver Evaluation	$100,000	$50,000	$50,000
Total	$1,195,307	$1,132,298	$1,133,198
State Share	$597,654	$566,149	$566,599
Federal Share	$597,654	$566,149	$566,599

(Federal State Match 50%/50%)

***** *DMA Staff (2) for Operations, Monitoring PIHP Compliance, Expenditures; PIHP Staff (.5 X 8 PIHPs=4) for Increase in Network Development, UM functions, Monitoring; Training PIHPs and Providers and Evaluation of Waiver*

Findings, Options and Recommendations

Section 5.1.(b) of S.L. 2015-135 requires the Department to report other findings and any other options or recommendations to best serve children with Serious Emotional Disturbance.

Currently there is significant data on the positive outcomes and the effectiveness of providing access to HCBS for children with serious emotional disturbance. While there are other Medicaid authorities under which this may be done, it appears that a 1915(c) waiver is the best authority to pursue at this time, in light of the other initiatives already under way in North Carolina. 1915(c) waivers are often implemented along with a 1915(b) that the Department currently operates for the management of other behavioral health services.

Some states such as Maryland, have designed HCBS state plan amendments under the 1915(i) authority, which allows for states to add HCBS to its Medicaid benefits under a State Plan amendment and does not require beneficiaries to meet an institutional level of care to receive services. However, it does not allow states to control the number of recipients receiving services. HCBS become an entitlement under the state's Medicaid plan. Growth and expansion of expenditures cannot be controlled through the authorization of slots as allowed under a 1915(c) waiver.

Another option adopted by some states in the absence of a 1915(c) waiver would be for the General Assembly to authorize funding for Wraparound Facilitation and Family Peer Support as new optional rehabilitative services covered under the Medicaid State Plan, with CMS approval. While these would become entitlement services, the services would be managed by the PIHPs and could contribute to cost savings by providing additional effective services in the community and reducing the current high use of PRTF services.

Other states such as Kansas are using the 1915(c) authority along with an 1115 Demonstration Waiver. The PRTF Demonstration Waiver in Kansas was amended to meet CMS requirements and approved to operate with the state's 1115 waiver.

Recommendations to Best Serve Children with Serious Emotional Disturbance

The North Carolina General Assembly has taken significant steps toward better meeting the needs of children with SED by providing funding for training for practitioners in proven, cost effective, evidence-based practices. The North Carolina Child Treatment Program, under contract with the Department's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, is providing the trainings through learning collaboratives on four evidence-based treatments for children. The availability of training for licensed therapists has greatly increased children and families' access to high quality, cost-effective trauma treatment. Continued funding of this initiative is recommended because the demand currently exceeds the program's capacity.

As North Carolina moves into the transformation of Medicaid, it will be critical to ensure workforce readiness to provide evidence informed services in the locations most children are found—schools and primary care offices. Clinicians in these settings will need specialized training while clinicians across the behavioral health system could benefit from more access to training in core competencies. In addition, the waiver would be in line with efforts toward integration with primary care.

An area of serious concern relates to the critical need, but lack of available resources for mental health and substance use treatment for parents of children who are in the foster care system, a large percentage of whom have serious emotional disturbances. When a local department of social service assumes custody of

a child, their parents often lose Medicaid coverage. But frequently it is the drug use or mental health issues that have caused children to be removed from their parents and placed in the care and custody of the state. These untreated mental health or substance use disorders become a barrier to a child's return to the family, increasing the trauma to the child as well as the accumulative costs to the state to maintain a child in care. It is recommended that the General Assembly authorize the Department to conduct an in-depth study on non-Medicaid funding options for this critical treatment for parents of children served by the foster care program, and make recommendations on possible funding mechanisms, cost sharing or other ways of securing much needed treatment for parents so that children can return home safely, and families can successfully thrive in their communities.

Conclusion

Based on the rigorous analysis of cost, service array, and benefits achieved by other states, it appears feasible to seek CMS approval for a 1915(c) waiver for children with Serious Emotional Disturbance. However, implementation would require carefully sequenced planning including workforce development and training and support by the PIHPs. North Carolina's children and families would have the choice to have a child with SED remain at home and in the community and avoid placement in a restrictive institution. Children with SED and their families could experience positive outcomes. Furthermore, the State Medicaid program could see cost savings with the use of HCBS in lieu of PRTF institutional costs.

Endnotes

[1] Kansas 1115 Waiver, approved. Located under Kansas at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/dynamic-list/WA-508.xml

[2] O. Urdapilleta, G. Kim, Y. Wang, J. Howard, R. Varghese, G. Waterman, S. Busam and C. Palmisano. *National Evaluation of the Medicaid Demonstration Waiver Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities*. IMPAQ International for the Centers for Medicare & Medicaid Services. May 2012. (Amended April 2, 2013), page 36.
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/CBA-Evaluation-Final.pdf

[3] Urdappilleta et al, May 2012, Amended April 2, 2013, Pages 36-37.

[4] Joint CMCS and SAMHSA Informational Bulletin, May 7, 2013, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*, Page 2. Cindy Mann, Director, Center for Medicaid and CHIP Services; and Pamela S. Hyde, J.D., Administrator
Substance Abuse and Mental Health Services Administration
http://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf

[5] Urdappilleta et al, May 2012, amended April 2, 2013, Page 7.

[6] Sheila A. Pires, Human Service Collaborative, *Customizing Medicaid Managed Care Systems for Children in Child Welfare*, Presentation at the Three Branch Institute on Child Social and Emotional Well-Being, Virginia State Team Meeting, Richmond, Virginia, September 24, 2013.

[7] Magellan Health Services, White Paper, *Perspectives on Residential and Community-Based Treatment for Youth and Families* prepared by Magellan Health Services Children's Services Task Force (2010),Magellan Health Services, Children's Services Task Force, 23rd Annual Children's Mental Health Research & Policy Conference March 7-10, 2010.

[8] Joint CMCS and SAMHSA Informational Bulletin, May 7, 2013; Page 3.

[9] *Wraparound Basics*, National Wraparound Initiative Website: http://nwi.pdx.edu/wraparound-basics/

[10] *Wraparound Basics*, National Wraparound Initiative Website: http://nwi.pdx.edu/wraparound-basics/

[11] System of Care Expansion Grant, awarded the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services.

[12] Kamala D. Allen, MHS and Taylor Hendricks, MS; *Medicaid and Children in Foster Care*, Center for Health Care Services, March 2013.

[13] S. Pires, K. Grimes, T. Gilmer, K. Allen, R. Mahadevan. Faces of Medicaid: "Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies. December 2013, Slide 4.
Access the full report: http://www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3

[14] S. Pires, K. Grimes, T. Gilmer, K. Allen, R. Mahadevan. Faces of Medicaid: "Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies. December 2013, Slide 7.
Access the full report: http://www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3.

[15] S. Pires, K. Grimes, T. Gilmer, K. Allen, R. Mahadevan. Faces of Medicaid: "Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies. December 2013, Slide 8. Access the full report: http://www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3

[16] Joint CMCS and SAMHSA Informational Bulletin, May 7, 2013; Pages 3-6.

[17] Sheila A. Pires, Jody Levison-Johnson Elizabeth Manley, Jackie Shipp, Dayana Simons, Michelle Zabel. *Customizing Care Coordination in Medicaid Delivery Systems for Children with Serious Behavioral Health challenges: The Use of Care Management Entities and Wraparound Teams,* Presentation at the Georgetown University Training Institutes, 2014.

[18] Urdappilleta et al, May 2012, amended April 2, 2013, Page 7.

[19] Search By State and Waiver Type: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/dynamic-list/WA-508.xml