

# USING MEDICAID TO OBTAIN INTENSIVE HOME-BASED SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

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## I. Introduction

There is an emerging national consensus that intensive home-based services are the most effective treatment for children with Serious Emotional Disturbance (SED). Since Medicaid, and specifically the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of the Act, require that States provide all medically necessary mental health treatment to children that will treat or ameliorate their conditions, it is arguable that States must offer intensive home-based services to all children who would benefit from them.<sup>1</sup>

But while there may be a consensus that these services are useful and effective for SED children, there is less agreement on exactly what they are; whether their definition and programmatic integrity depend on a specific philosophy and values; whether their effectiveness is measured by evaluating discrete service components or the entire treatment program; whether each discrete element, as opposed to the total treatment program, is covered under Medicaid; whether their effectiveness depend on interagency collaboration and funding; and whether they are a process or a method for delivery services as well as a distinct treatment. This paper attempts to address these issues. A subsequent paper will address the claims and decision in *Rosie D. v. Romney*, a pending class action in Massachusetts that seeks intensive home-based services under EPSDT for a class of SED children, including whether they are sufficiently coherent and established that a court would order a state to provide them.

## II. Intensive Home-Based Services Are A Single Treatment

There is no clearly established and universally accepted definition of intensive home-based services. While thirty-five states provide some form of intensive home-based services through their Medicaid or EPSDT programs, *see* Koyanagi, Chris, Making Medicaid Work (Bazelon Center 2000), they do not necessarily provide the same services or the same constellation of services. This is in part due to inevitably differences in state program descriptions, local design decisions, and

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<sup>1</sup> Clearly, a State's obligation to provide intensive home-based services is limited to services that are covered under the Medicaid Act. *See* section IV, *infra*. Any legal claim of entitlement to intensive home-based services must define this treatment as a category of medical assistance. Consequently, for the purpose of this paper, and EPSDT claims generally, intensive home-based services do not include non-medical educational or social services (i.e. food, clothing or rental allowances), or some forms of flexible supports (i.e. babysitting) that clearly are not covered by the Act.

coverage rules, but it primarily reflects the reality that intensive home-based services are a constellation of services unified and integrated through a single treatment team and plan. Thus, the very nature of this treatment invites the criticism that it is not a single treatment at all, but a combination of discrete interventions that States may offer separately or in any reasonable combination.

To respond to these arguments, several national experts developed the following definition of intensive home-based services that was used in the *Rosie D.* case:

Home and community-based services are a well-established behavioral health intervention for children designed to meet the child=s needs in his/her home and home community. They may be provided in the child=s natural or foster home, or in the community where the child lives. The planning and provision of home and community-based services require a specific, individualized process that focuses on the strengths and needs of the child and the importance of the family in supporting the child. Home and community-based services incorporate several discrete clinical interventions, including, at a minimum, comprehensive strength-based assessments, crisis services, case management, clinical teams, and individualized supports including behavioral specialists. These services must be provided in a flexible manner with sufficient duration, intensity, and frequency to address the child=s needs.

The definition subsequently was supplemented by several unifying and integrating elements of intensive home-based services: a single treatment plan developed by a single team comprised of the family and all relevant professionals that is coordinated and monitored by a single case manager. The emphasis on a single team, plan, and manager is both the most critical factor in the effectiveness of intensive home-based services, as well as the defining feature of these services as a single treatment, rather than simply a composite of discrete interventions.

### **III. Intensive Home-Based Services Are An Effective Treatment**

Research has demonstrated the effectiveness of intensive home-based services for SED children and their families or foster families. Randomized trials, other research studies, and broad and deep experience with the implementation of intensive home-based services across the country confirm that intensive home-based services are beneficial for SED children. In particular, a significant number of randomized trials have demonstrated the clinical effectiveness of their component services, including case management, multi-systemic therapy, treatment foster care, family supports, clinical supports and behavioral aides. In addition to these randomized trials, observational and quasi-experimental studies concerning case management, integrated treatment planning, behavioral aides and mentoring further supports the effectiveness of intensive home-based services.<sup>2</sup>

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<sup>2</sup> A comprehensive list of the literature and evaluations of home-based services is attached as Appendix A.

There is less research and published literature on the integration of these elements into intensive home-based services. The federal government has created and greatly expanded a national initiative to support systems of care for children and families.<sup>3</sup> It specifically included an evaluation component in the initiative to test the effectiveness of home and community-based services.<sup>4</sup>

The services provided in system of care sites correspond generally to the definition of home and community-based services above. These findings provide a picture of early gains for a large sample of youth in multiple program sites across the country.

- Behavioral and emotional strengths improved -- Almost 50% of the caregivers reported significant improvements in their children's strengths, as measured by the Behavioral and Emotional Rating Scale.
- Behavioral and emotional problems were reduced -- 36% of children showed significant improvement in their total problem behaviors, as measured by the Child Behavior Checklist.

**Comment [BJB1]:** Same logic as before; clarification added above.

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<sup>3</sup> The term “systems of care” is widely used but not clearly defined. At some level, all methods of providing medical assistance are a system of care. In the children’s mental health field, the term has come to mean a treatment planning and delivery process, conducted pursuant to certain service delivery principles (the “CASSP principles”), that offer a range of treatment interventions collectively referred to as home-based services.

<sup>4</sup> The Comprehensive Community Mental Health Services for Children and Their Families Program is the Nation’s principal response to the service needs of the estimated 4.5 to 6.3 million children who have a serious emotional disturbance and their families. It provides grants to states, communities, territories, and America Indian tribes to improve their mental health service systems to meet the needs of children and adolescents with serious emotional disturbance and their families through home-based services and systems of care.

From 1993 to 2001, federal grants grew from \$5 million to \$464 million, the largest federal investment ever in community-based mental health services for children and their families. As of April 2001, a total of 47,303 children and their families had been served. The evaluation of this national grant program and its local grantees is designed to address many complex issues and related dimensions of effectiveness. It includes a longitudinal study to address changes in youth over time, a comprehensive assessment of outcomes across several domains and an evaluation of services and service delivery systems.

- Functional impairment was reduced -- Improvement in overall functioning in society and interactions with others, as measured by the Child and Adolescent Functional Assessment Scale.
- School performance improved -- School achievement improved across the board during the first six months. Failing grades fell from 17% to 14%; children receiving a “D” fell from 15% to 9%; and the percentage of children with a passing grade (“C” or better) increased from 58.9% to 65.8%.
- Law enforcement contacts were reduced -- 25% reduction in the number of youth who spent time in jails and detention facilities.
- Residential stability improved -- Single residential living arrangements among children who remained in services for six months increased 14%.

National experts and the professional literature they have produced, establish that intensive home-based services are widely accepted by mental health researchers and clinicians as an effective and superior treatment for children with SED. Among other benefits, intensive home-based services prevent placement of SED children in more restrictive out-of-home placements, such as hospitals or residential facilities, improve functioning, improve school attendance and performance, and decrease aggressive behavior. Intensive home-based services are effective because they reflect the interactions and relationships of the family, consider family, community, and environmental factors that contribute to the child’s condition, and directly reinforce the connection with home and community. Intensive home-based services can avoid institutionalization and restraint. Children with SED who are provided intensive home-based services can live productive lives in the community, attend regular schools and make educational progress, and avoid involvement with the criminal justice system. Providing intensive home-based treatment early in a child’s life increases the services’ likelihood of success.

Mental health practitioners around the country have adopted intensive home-based services with great success. Evaluations of intensive home-based services delivered in a number of locations, such as Wisconsin and Rhode Island, have demonstrated reductions in residential placements and hospitalizations, improved functioning and improved school performance. In Wisconsin, Wraparound Milwaukee (“WAM”) has demonstrated a 30% improvement in CAFAS scores as well as a 60% reduction in juvenile justice recidivism rates. WAM has also reduced residential treatment placements in Milwaukee County from a daily average of 375 to 75 placements and further reduced the use of psychiatric inpatient care from approximately 5,000 days to less than 200 days per year for SED youth. Rhode Island’s statewide program, Children’s Intensive Services, demonstrated a 50% decrease in the utilization of psychiatric beds and improved functioning in a majority of participating children in Providence.

These findings are supported by the Surgeon General, in his 1999 Report on children's mental health. It concluded that with respect to children's mental health in particular, there is a "strong record for effectiveness for home-based services, which provide very intensive services within the home of children and youth with serious emotional disturbances." See U.S. Department of Health and Human Services. (1999). Mental health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. They were subsequently adopted by the President's New Freedom Commission, in its 2004 Report, which noted that intensive home-based services were among the most promising treatment interventions for children with serious emotional disturbance. See President's New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America, final report. (Pub. No. SMA-03-3832. Rockville: Department of Health and Human Services. These two prestigious reports lend considerable credence to the claim that intensive home-based services are an established and effective treatment for SED children.

#### **IV. Intensive Home-Based Services Are A Covered Treatment**

While there is no specific reference to intensive home-based services in the list of Medicaid covered services, see 42 U.S.C. sec. 1396d(a)(1)-(28), States regularly describe, and CMS regularly considers, intensive home-based services to be within the broad definition of rehabilitative services, as described in § 1396d(a)(13).<sup>5</sup> A 1999 study of Medicaid contracts and state plans revealed that thirty-five states offer intensive home-based services in their EPSDT program, most using the category of rehabilitative services. See Making Sense of Medicaid for Children with Serious Emotional Disturbance (Bazelon Center 1999). Since the Act's definition of rehabilitative services specifically includes services provided in the home, since its broad coverage clearly encompasses behavior training, crisis services, and various therapies, and since its standard is that which is necessary to achieve or maintain "best possible functional level," rehabilitative services is uniquely suited for incorporating intensive home-based services. While not every element of certain States' intensive home-based services program may properly be considered medical assistance and eligible for Federal Financial Participation (FFP) under the Act, it is clear that most are, and that States offer home-based services as a covered Medicaid service.<sup>6</sup>

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<sup>5</sup> Rehabilitative services are defined as: other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

<sup>6</sup> A significant number of states offer intensive home-based services to children as a Medicaid covered service. When offered as an integrated treatment on a statewide basis, such as

States do not need a federal waiver to provide intensive home-based services. In fact, many states that do not have a waiver cover these services under their Medicaid or EPSDT programs. Many States provide Medicaid-eligible children with intensive home-based services, including a comprehensive assessment for home-based services, a single treatment team, a single treatment plan, a single case manager with the authority to access needed treatment for as long as necessary, in-home crisis services, and behavior therapy provided by a behavior specialist who can work with the child in the home and community. Some of the states that provide intensive home-based services as part of their EPSDT program include: Alabama, Arizona, Delaware, Indiana, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, and Wisconsin.

## **V. Intensive Home-Based Services Are A Treatment And Not Just A Service Delivery or Planning Process**

Because intensive home-based services are planned, delivered, and monitored are part of an integrated treatment planning process, some critics and commentators have described these services as a process rather than a treatment. This view is probably the result of confusion between the term “wraparound” program, which has traditionally been viewed as a process and set of programmatic principles, and intensive home-based services. It is aggravated by the reality that intensive home-based services are not a single mental health intervention, but instead, a composite of interventions organized and delivered as a single program, through a single treatment team and plan. Since States are mandated to offer medically necessary treatment, but not specific processes for planning or delivering that treatment, it is critical to overcome this confusion and successfully describe intensive home-based services as a single treatment, not a planning process or service delivery method.

Intensive home-based services constitute a single treatment that has multiple components. Like an early intervention program or psychiatric hospitalization, it can include several distinct clinical interventions, such as assessments, medication, and therapies, they must be integrated through a treatment team and case manager. The treatment team and coordinator of services are essential, and cannot be separated from the specific interventions. Both the process of delivering the services and the service itself, such as a behavioral specialist, are essential and complementary components of this integrated treatment. Together they constitute the intensive home-based services treatment or intervention.

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in Pennsylvania, New Jersey, or Rhode Island, intensive home-based services are generally funded entirely through Medicaid. Where intensive home-based services are offered in specific cities as part of a larger system of care incorporating non-reimbursable services, such as MHSPY and WAM, such systems are only partially funded by Medicaid. This is both because Medicaid cannot be used for activities such as rent vouchers or summer camp, which are not medical assistance as defined in the Act, and because systems of care generally include multiple sources of funding.

## **VI. Intensive Home-Based Services Are A Treatment And Not Just A Method Or Organizational Structure For Delivering Care**

Similarly, because intensive home-based services are commonly incorporated in a system of care structure, some critics and commentator have described these services as the method for organizing care, rather than as the treatment itself. This view is probably the result of confusion about the origin of home-based services, which had its genesis in systems of care initiatives funded by the federal government and incorporated in SAMHSA's national evaluation of children's mental health initiatives. *See* section III, *supra*. Since States are not obligated to adopt any particular organizational method for providing medically necessary treatment, and, in fact, probably have discretion under the Act to adopt any method they elect as long as it is reasonable, it is critical to rebut the assertion that intensive home-based services are simply a structure for organizing treatment, rather than the treatment itself.

Intensive home-based services are uniformly recognized as a clinical intervention employing a single provider to deliver a single, integrated treatment focused upon one child. In contrast, a system of care organizes and funds the provision of virtually all possible services, from hospitalization to outpatient programs, delivered by assorted providers and governmental agencies to many children at various locations. Given their breadth, there are many varieties of systems of care, each offering a different spectrum of services. While systems of care may include intensive home-based services, they need not, and often do not, provide such services.<sup>7</sup>

## **VII. Conclusion**

Intensive home-based services are a critical and effective treatment for children. Their effectiveness has been established through myriad studies, evaluations, and practical demonstration programs. As such, they should be covered by Medicaid, through its EPSDT mandate, for all children who need them. Demonstrating that intensive home-based services are a single treatment, covered as medical assistance under the Act, is challenging, but if advocates carefully define – and limit – the requested services, taking care to frame them as a single, unified treatment and not a process or method for delivering services, they should be able to obtain them under Medicaid.

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<sup>7</sup> This distinction is reinforced by both the structure and content of the 1999 Surgeon General's Report on Mental Health. Chapter 3 of the Report includes separate headings labeled "Services Interventions" and "Service Delivery." Significantly, the "strong record of effectiveness for home-based services" is addressed within the former section concerning services and interventions. In contrast, the "Service Delivery" section explicitly notes, before discussing systems of care and the studies that "[t]he focus of this section is on service systems – their origins, nature, and financing and also their effectiveness, delivery, and utilization – rather than on individual interventions and treatments, which were covered in previous sections of this chapter."

## APPENDIX A

### CONTROLLED STUDIES OF HOME AND COMMUNITY-BASED SERVICES FOR CHILDREN AND ADOLESCENTS

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#### INTENSIVE CASE MANAGEMENT (including WRAPAROUND)

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