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BRIEF

JULY 2016

Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Intensive In-Home Services

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This document was prepared for the Technical Assistance Network for Children's Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Contract #HHSS280201300002C. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Evidence from the Psychiatric Residential Treatment Facility (PRTF) Demonstration Program and the Children's Mental Health Initiative (CMHI) program have consistently found that the availability of home and community-based services (HCBS) have improved the quality of life for children with serious behavioral health challenges and their families (e.g., improved school attendance and performance; improved clinical and functional outcomes; more stable living situations, etc.).[1,2] In addition to the positive social and clinical benefits for youth and families, community-based alternatives to "deep-end" placements like residential care are also cost effective. As found during a recent investigation exploring financing of systems of care approaches for children with behavioral health challenges found, public purchasers who invest in expanding the availability of HCBS receive significant return on investment in terms of improved clinical and functional outcomes for youth as well as financial savings.[3] In its review of children's behavioral health service utilization and expenditures, the Center for Healthcare Strategies found that congregate care settings, such as residential care and group homes, accounted for 19.2 percent of total behavioral health expenditures among children on Medicaid, the largest percentage of total expenditures. In contrast, spending on all HCBS services combined[4] was less than 10 percent of total behavioral health expenditures for youth on Medicaid.[5] HCBS that support families so children can live in their own homes are a fundamental component of the Children's System of Care.

Intensive-In-Home Services (IIHS) is a HCBS service that states and communities are increasingly including in their service arrays as an alternative to costly out-of-home care. IIHS is not simply outpatient therapy delivered in a home environment, but rather a comprehensive intervention that includes individual and family therapy, skills training and behavioral interventions, crisis response, and care coordination. IIHS are designed to be maximally flexible, delivered at times and locations selected by the youth and family. By conducting the assessment, treatment planning, and interventions in the youth and family's home, school, and/or community, it allows for customization of services to the youth and their unique familial and environmental contexts. Unlike typical outpatient individual or family therapy that occurs in an office, IIHS offer the opportunity for trained staff to help youth and families practice skills in real world settings, increasing the likelihood that they will be able to apply these skills to a range of everyday situations.

Some states have even used the IIHS platform to implement certain evidence-based practices (EBPs) like Functional Family Therapy (FFT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST). This allows states to help youth and families struggling with specific issues such as trauma, substance use, or conduct problems. Increasingly, EBPs have been viewed as prudent

investments by public purchasers due to their documented success at achieving positive benefits for youth and families while reducing spending on high-cost/poor-outcome interventions such as residential treatment or emergency department use.

In May 2013, the Centers for Medicaid and CHIP Services (CMCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a joint informational bulletin providing guidance to states on designing HCBS, including IIHS, to help them meet their obligations under Title II of the Americans with Disabilities Act[6] (ADA) and Medicaid's Early Periodic Screening, Diagnostic and Treatment[7] (EPSDT) requirements. As the federal government encourages more states and communities to include IIHS in their benefit/service designs, there is a need to better understand what these services look like from an operational perspective. Information on service definitions, rate setting methodology, provider qualifications, financing strategies and quality measures for performance management is needed by states and localities to improve the availability of IIHS services and to help them implement IIHS in their jurisdictions.

This publication is intended for use by state and local family and youth organizations; Medicaid; and child serving agencies, providers and other stakeholders engaged in the design, implementation and/or expansion of IIHS. IIHS can and do look different from state to state with variability dependent on the purchaser, the financing environment and the population served. This resource provides examples of how IIHS has been operationalized in states including Connecticut, Massachusetts, Michigan, Montana, and North Carolina to help guide planning, design and implementation efforts in other states and jurisdictions across the country.

Intensive-In-Home Services Defined

In their joint information bulletin, CMCS/SAMHSA defined IIHS as, "…therapeutic interventions delivered to children and families in their homes and 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."[8] In addition to the aforementioned components, many states such as Connecticut, Massachusetts, North Carolina and Ohio have expanded the scope of IIHS to include 24/7 urgent response and care coordination. North Carolina, for example, requires that its IIHS teams serve as "first responders" for the youth and families they serve who experience mental health crises. Ohio permits its IIHS providers to offer crisis response through written agreement with another agency, as long as a staff person from the IIHS provider agency is available to the youth and family and the crisis response provider should the need arise.

With respect to care coordination, Massachusetts mandates that its IIHS providers assist families with identifying community resources and natural supports, collaborate with state agencies and other formal service providers, and make referrals and linkages to appropriate services along the continuum of care. Ohio requires that its IIHS clinicians assume the lead clinical role and coordinate all mental health services for youth they are working with. This includes developing and maintaining positive relationships with other professionals, developing natural supports and resources, and taking a primary role in scheduling and facilitating collaborative meetings in the community.

As mentioned earlier, some states have used IIHS to implement certain EBPs. When this is the case, the service must be delivered in accordance with the specific guidelines created by the treatment model developer. For example, FFT, one of the intensive in-home EBPs available to youth and families in Connecticut, follows specific phases during which interventions such as psychoeducation, safety planning, coping skills development and practice, conflict management, and affect regulation are employed to help adolescents and their families recover from trauma.

Implementation Essentials

Oversight and purchasing

Purchasers of IIHS for youth with serious behavioral health challenges are typically state Medicaid, child welfare, and mental health agencies. These entities typically purchase IIHS from community mental health centers or other non-profit behavioral health provider organizations. For example, Connecticut's Department of Children & Families (DCF), a consolidated children's agency that oversees mental health, substance use, juvenile justice and child welfare, purchases IIHS on behalf of youth who are returning home from or are at risk of out-of-home placement or psychiatric hospitalization. Montana's Department of Public Health and Human Services, Children's Mental Health Bureau, purchases IIHS services using Medicaid funds from community-based service human service providers. In Michigan, IIHS are purchased by the Department of Community Health, Division of Mental Health Services to Children and Families, using Medicaid dollars, and accessed through a network of local community mental health services programs (CMHSPs). Massachusetts Medicaid (MassHealth) contracts with six managed care entities[9] that are responsible for contracting with local mental health providers. In 2013, approximately 115 behavioral health providers delivered IIHS to more than 17,500 youth with behavioral health challenges in Massachusetts.

In-Home Therapy Service Definition – Massachusetts Medicaid (MassHealth)

Developing a clear definition of the service being purchased is an important first step when implementing a new service. This helps purchasers, service providers, family members, and other system partners understand what the service is supposed to look like "on the ground." It provides clarity about what activities are and are not expected as part of the service. The Massachusetts Medicaid program, commonly referred to as MassHealth, created the following service definition to guide its provider network:

"In-Home Therapy is a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. Interventions are designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. The In-Home Therapy team (comprised of the qualified practitioner(s), family, and youth), develops a treatment plan and, using established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, communication, build skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; develop and maintain natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention."

Massachusetts Executive Office of Health and Human Services, MassHealth
http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-in-home-therapy.pdf

Eligibility and screening

Another important aspect of implementing IIHS is establishing clear eligibility criteria. This helps ensure that those youth who are most in need of the service can access it. States utilize standardized screening or assessment tools, such as the Child and Adolescent Needs and Strengths (CANS) tool or the Child and Adolescent Service Intensity Instrument (CASII), to establish eligibility for IIHS or for a larger program or package of services of which IIHS is a part. For example, Michigan requires that its child

mental health professionals delivering IIHS use the Child and Adolescent Functional Assessment Scale (CAFAS)[10] to assist in determining level of functioning and criteria for the state's 1915(i) Home and Community-Based Services (HCBS) program (see box) as determined by the state's Utilization Review (UR) contractor, and must then have a face-to-face independent assessment conducted by a qualified individual[11] to determine if the child needs at least one of the 1915(i) services such as IIHS. In Massachusetts, medical necessity criteria were drafted to clearly outline the youth and family characteristics necessary for participation in the service. To assist in this determination, providers must conduct a comprehensive behavioral health assessment that includes use of the Child and Adolescent Needs and Strengths (CANS) tool. Providers must seek authorization from the youth's managed care entity, which is ultimately responsible for determining if the youth is eligible for the service. North Carolina also drafted specific medical necessity criteria to assist in determining eligibility for IIHS. Providers must conduct a comprehensive clinical assessment and a signed service order must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to his or her scope of practice. Prior to service delivery initiation, the provider must obtain authorization from the local management entity managed care organization (LME - MCO).

For youth who meet the established eligibility criteria and are enrolled in the IIHS service, the average length of involvement varies and is based on the specific needs of the youth and family. In Ohio, IIHS is expected not to exceed six months for most families, with a continued stay review required for any youth/family needing treatment beyond six months, and subsequent reviews occurring every forty-five days thereafter. North Carolina does not have a suggested length of stay but does expect that the intensity of the service will diminish over time. For example, the state requires that the provider meet with the family for a minimum of two hours and have 12 face-to-face contacts in the first month of treatment, with at least six face-to-face visits required in the second and third months of the service.

Population Served – Connecticut Department of Children and Families (DCF)

Understanding who the service is intended to help will ensure that the right children and families have access to the service. It also assists service providers to develop awareness of the skills and competencies their staff should possess to meet the needs of the children they are caring for. Defining the "who" also assists family members and other referral sources as they consider if the service is the right one for the child.

Connecticut's IIHS includes an array of evidence-based practices intended to meet the needs of youth and families with a variety of behavioral health challenges. Target population descriptions were crafted for each of the four services that fall under the IIHS umbrella. The target populations for two of these services, Multidimensional Family Therapy (MDFT) and Functional Family Therapy (FFT) are described below:

"MDFT is an Intensive Home-Based program that serves children and youth who have behavioral health needs such as substance abuse and/or co-occurring disorders, and their families. MDFT offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to substance abuse or co-occurring disorders. Eligibility for MDFT services does not require DCF-involvement. Referrals to MDFT are typically made by the DCF Area Offices, System-of-Care Collaboratives, Juvenile Justice staff, and community providers.

FFT teams offer intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Eligibility for services does not require DCF-involvement. Referrals to FFT are typically made by the DCF Area Offices, System-of-Care Collaboratives, and community providers."

Connecticut Department of Children & Families:
http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314366

FFT, one of the EBPs offered in Connecticut, requires that clinicians deliver approximately 12 sessions of family therapy, which typically occur 1-2 times per week for 1-2 hours over a 3-6 month period. Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), another Connecticut EBP, is delivered by a team of two staff who meet with the youth and family two times per week for approximately an hour and a half, with an average length of stay of six months.

Eligibility Criteria – Montana Department of Public Health and Human Services

Access to IIHS in Montana is limited to those youth who meet the criteria for the state's Medicaid 1915(i) Home and Community Based Services State Plan Program. Only those youth who are living in a "family home setting" are eligible for IIHS care under the 1915(i) program, as services cannot be provided in a hospital or psychiatric residential treatment facility (PRTF). In addition youth must meet the following criteria:

1. Is age five through 17, or to the age of 20 if the youth is still in secondary school and consents to participation in the 1915(i) HCBS State Plan Program;
2. Is Medicaid eligible;
3. Meets the clinical criteria of serious emotional disturbance; and has at least two of the following risk factors:
    a. Has had at least one admission to a PRTF in the past 12 months;
    b. Has had at least one admission to a local in-patient hospital related to behavioral health needs, not physical health needs, in the past 12 months;
    c. Has had at least one admission to a therapeutic group home in the past 12 months;
    d. In lieu of 1915(i) HCBS State Plan services, the youth is at risk of placement in a PRTF per an assessment of referral information.

    OR has at least one of (a)-(d) above AND is receiving three (3) or more of the following types of outpatient services in the community setting and is not making progress:
    - Outpatient therapy with or without medication management;
    - Comprehensive School and Community Treatment;
    - Day treatment OR partial hospitalization;
    - Therapeutic family care OR therapeutic foster care; or
    - Respite
4. The services can reasonably be expected to improve the condition of the youth or prevent further regression.

Montana Department of Public Health and Human Services, Children's Mental Health Bureau, 1915(i) Home and Community Based Services State Plan Program for Youth with Serious Emotional Disturbance (SED) Policy Manual: https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/FINAL915(i)HCBSProviderPolicyManualOct15.pdf

Provider qualifications and training

Clearly defining the requisite skills, competencies and experience a provider must possess in order to deliver IIHS is one way states promote quality of care and ensure the safety and well-being of youth receiving IIHS. States typically will define the *types* of providers who can deliver IIHS (e.g., hospitals, community mental health centers, etc.) as well as the *standards or qualifications the people* providing the service must meet (e.g., master's degree; licensed social worker; possess a valid driver's license; experience working with youth with SED; etc.).

In many states, IIHS is delivered by a team that is typically composed of a bachelor's level staff person and a master's level mental health professional. Each member of the team has a specific role and job responsibilities. Qualifications are commensurate with each role. In Massachusetts, for example, IIHS are typically provided by a two-person team consisting of a bachelor's level staff person and a master's level clinician. The bachelor's level staff person (referred to as a Therapeutic Training and Support staff person [TT&S]) works under the supervision of the mental health clinician, assisting the clinician in implementing the goals on the youth's in-home therapy treatment plan. Michigan's IIHS allows for teams that include a home-based services worker who must meet the child mental health professional qualifications, and a home-based service assistant who meets the established definition of a mental health aide (see box). Additionally, IIHS supervisors in Michigan must have a master's degree, meet the established child mental health professional qualifications, and have an additional three years of professional experience. In North Carolina, certain IIHS provider teams specialize in working with youth who have substance use disorders. Thus the team is required to include at least one staff person who is licensed or certified to deliver addiction services in the state.

Provider Qualifications – Michigan Department of Community Health

Providers interested in delivering home-based services in Michigan must be certified by the Michigan Division of Mental Health Services to Children and Families. Home-based services are operated through the state's network of local Community Mental Health Services Programs (CMHSPs). The individuals delivering home-based services through these CMHSPs must meet the following qualifications:

Minimum qualifications
All providers must be: At least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law (e.g., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Licensed professionals must act within the scope of practice defined by their licenses. "Supervision" is defined by the Occupational Regulations Section of the Michigan Public Health Code at MCL§333.16109 and, as appropriate, in the administrative rules that govern licensed, certified and registered professionals.

Specific qualifications for IIHS team members
The home-based services worker must be a Child Mental Health Professional (CMHP) which is an: Individual with specialized training (e.g., fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience. The time spent in fieldwork or internship can be counted toward the one-year experience requirement and must be documented by the student's supervisor or the program's coordinator for fieldwork/internships) **and** one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; **or** an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; **or** an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families. For the Autism Benefit, must have minimum of master's degree and one year of experience in the evaluation and treatment of children with autism spectrum disorder (ASD). UNLESS the home-based services worker is providing mental health therapy, which requires the individual to be a physician, psychologist, licensed master's social worker (or a limited-licensed master's social worker supervised by a licensed master's social worker), or a licensed or limited-licensed professional counselor + one year of experience in examination, evaluation and treatment of minors and their families.

Individuals working with youth between the ages of 7-17 with Serious Emotional Disturbance (SED) must be trained in the CAFAS.

Home-based services assistant must be an Aide which is defined as an: Individual who is able to perform basic first aid procedures and is trained in the beneficiary's plan of service, as applicable. Aides serving children on the Children's Waiver and the Waiver for Children with Serious Emotional Disturbance (SEDW) must also be trained in recipient rights and emergency procedures. Additionally, aides serving children on the Children's Waiver must be employees of the CMHSP or its contract agency, or be an employee of the parent who is paid through the Choice Voucher arrangement. Aides serving children on the Autism Benefit must also receive training in the principles of behavior, behavioral measurement and data collection, function of behaviors, basic concepts of ABA, generalization and its importance in sustainability of learned/acquired skills, and medical conditions/illness that impact behaviors.

Michigan Department of Community Health, Provider Qualifications Per Medicaid Services & HCPCS/CPT codes
http://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf

Given that it is not uncommon for youth served through IIHS to have complex diagnoses and prescribed psychotropic medications, some states have psychiatric staff as part of the IIHS team. Massachusetts, for example, requires that its IIHS teams have access to a board-certified or board-eligible child psychiatrist or a child-trained mental health psychiatric nurse clinical specialist, who is available during normal business hours for consultation related to treatment planning, medication concerns, and crisis intervention. The psychiatric clinician must be available for consultation to the IIHS team within one hour of request.

States also typically establish standards for supervision as an additional way to promote quality services. Strong clinical supervision is particularly important given that the youth and families served by IIHS teams have serious behavioral health challenges and frequently experience other psychosocial stressors such as housing instability, food insecurity and exposure to community violence. Ohio recommends that IIHS teams receive two hours of clinical supervision per week from an independently licensed supervisor who is specifically designated to the IIHS program. Further, given that the IIHS service is expected to be available to youth and families on a 24/7 basis, supervisors must also be available to their staff for emergency consultation and supervision as needed. As an additional level of clinical review and support, Ohio recommends that IIHS programs employ a structured team-based case review process. Massachusetts requires that IIHS teams receive supervision from a licensed master's level senior clinician on a weekly basis and that a senior-level licensed clinician is available to staff 24/7 on an as needed basis.

Expectations for the number of youth served by each IIHS team is an important variable to consider as offering this guideline helps providers better approximate the intensity of the service. Table 1 provides an overview of the IIHS team to youth/family ratio in several states. Some states like Massachusetts do not quantify youth to staff ratios for IIHS, but rather leave the number of youth served by each individual/team to be determined by the program supervisor based on the needs and complexity of the youth on the team's caseload and other factors such as how many youth are considered "new" versus those youth who are transitioning out of the service.

Table 1: IIHS team to youth/family ratios

STATE	BILLING CODES AND MODIFIERS
Connecticut	■ 1:5 is average with range from 1:4 to 1:6 (for MST)
Michigan	■ 1:12 with a maximum of 15 for those staff who have youth who are transitioning out of the service
North Carolina	■ 1:8
Ohio	■ 1:12 for teams of two ■ 1:8 when delivered by a single staff person

Clearly specifying the training required for IIHS helps ensure that staff people have the necessary competencies and skills to deliver the service. Responsibility for ensuring that providers meet the standards and qualifications for participation as a qualified IIHS provider may be held by the state purchaser, licensing authority, or delegated to another entity such as a managed behavioral healthcare organization (MBHO) or an administrative services organization.

Some states describe specific training activities or topics that providers delivering the service must ensure their staff meet, but leave the actual trainings up to the providers to arrange. Other states like Ohio, have partnered with a university to conduct training and coaching, and provide technical assistance for IIHS providers. When a state uses the IIHS platform to deliver EBPs, the training and credentialing requirements for the specific EBP are determined by the EBP purveyor. For example, providers of MDFT in Connecticut must be credentialed by the University of Miami (the MDFT developer), certified by the Connecticut DCF to deliver the service, and must participate in ongoing MDFT consultation and training conducted by the in-state, non-profit behavioral health management company that is under contract to DCF to support the statewide implementation of MDFT.

Financing

Financing a broad array of appropriate services and supports including IIHS is a key to helping youth with behavioral health challenges remain in the community. Medicaid, child welfare and mental health general revenue, and federal grant funds are all potential sources of funding. Exploring different funding streams and sources and pooling, blending, or braiding these funds together is an effective strategy for making IIHS available to diverse groups of youth with behavioral health challenges (e.g., uninsured youth, those with co-occurring disorders, youth involved with multiple child-serving systems, etc.). Connecticut, for example, blends money from its Medicaid program with child welfare dollars to support access to its intensive in-home service array for youth in that state.

Another financing strategy commonly used to support access to IIHS is redirecting money from high cost out-of-home care and investing these dollars in HCBS such as IIHS. This strategy allows public purchasers to serve more youth and receive better outcomes. Redirection and reinvestment have been critically important strategies for expanding access to HCBS for youth with behavioral health challenges (see box).

Intensive Home-Based Treatment Training (IHBT) Requirements – Ohio Mental Health & Addiction Services

Ohio understood that intensive in-home staff people were coming to the job with varying levels of knowledge, experience, skills, and competencies. With this in mind, they took an individualized approach to staff training. Each staff person receives an assessment of their initial training needs with 30 days of hire. This assessment includes review of the core skills and competencies necessary for providing in-home work: Family systems, risk assessment and crisis stabilization, parenting skills and supports for youth with SED, cultural competency, intersystem collaboration with a focus on schools, courts, and child welfare, trauma-informed care, educational and vocational functioning, and the IHBT philosophy, including strength-based assessment and treatment planning. Based on that assessment, an individualized training plan is created for the staff person. Within six months of the hire, each staff must have either documented competency in the aforementioned core skill areas or have participated in training in the core area.

Each IHBT supervisor is also required to receive training specific to the clinical and administrative supervision of IHBT. Ongoing quarterly trainings specific to the identified training needs of the staff as it related to the population served, including attention to cultural competency, changing demographics, new knowledge or research, and other areas identified by the agency.

Ohio Mental Health and Addiction Services IHBT Certification Standard: http://mha.ohio.gov/Portals/0/assets/Regulation/LicensureAndCertification/rules/5122-29-28-ihbt-service.pdf

Maximizing federal funding by leveraging the Medicaid program is another common strategy used by states to expand access to IIHS. States use a variety of different Medicaid authorities to do this. Montana used the 1915(i) HCBS State Plan authority to include IIHS along with several other services in its state Medicaid plan. Unlike 1915(c) waivers, there is no cost-neutrality requirement nor do individuals have to meet institutional level of care criteria; these functional differences in the structure of 1915(i) reduce historical barriers to states covering HCBS for children and adults with serious behavioral health challenges. Massachusetts included coverage of its IIHS (referred to as In-Home Therapy) in its Medicaid state plan under the auspices of Medicaid's comprehensive health benefit for youth under 21 known as EPSDT (Early and Periodic Screening, Diagnostic, and Treatment). Massachusetts delivers the benefit using a managed care platform under its long-standing Section 1115 demonstration referred to as MassHealth.

When using Medicaid funds, states have some discretion when developing their rates, but must follow certain federal guidelines that require that the methodology used to calculate the reimbursement rate is consistent with efficiency, economy, and quality of care. In states that pay for IIHS through a fee-for-service system, states can develop their rate based on the costs of providing the service, a percentage of what Medicare pays for equivalent services, or through a review of what commercial

payers pay in the private market. Many states utilize MBHOs as a vehicle for provider contracting and payment. When managed care arrangements are used, the state pays a monthly capitation (a set fee amount each month for each enrolled member) to the MBHO, which then pays the provider for services rendered.

In addition to establishing a reimbursement rate, billing codes must also be identified. See Table 2 for the codes used in various states and the unit rates where available.

Financing Strategies – Connecticut Behavioral Health Partnership

In response to a 2000 report by the Child Health and Development Institute of Connecticut that found that the state was spending 70% of its behavioral health services dollars on out-of-home care for only 19% of children, the state legislature called for the establishment of an integrated behavioral health service system based on systems of care principles. Started in 2005, the Connecticut Behavioral Health Partnership (CT BHP) blends funding from various sources including Medicaid, DCF, and the Department of Mental Health and Addiction Services to serve Medicaid enrollees and youth enrolled in DCF's voluntary services program. The CT BHP contracts with an Administrative Services Organization (ASO) to perform certain functions such as claims payment, customer service, utilization management, and quality assurance. The enabling legislation also established a Behavioral Health Partnership Oversight Council consisting of legislators, consumers, advocates, health care providers, managed care plans, and state agencies to monitor the activities of the BHP, support its ongoing implementation, and make recommendations to the state agencies and the Connecticut General Assembly.

For more information about the CT BHP visit: http://www.ctbhp.com/about.html

Redirecting spending from residential care – Reinvesting dollars in home and community based services

States have implemented various strategies in efforts to redirect resources away from expensive, residential services and reinvest those dollars in the expansion of home- and community-based service capacity.

Arizona used the 1115 Waiver to develop home and community-based alternatives to out-of-home services. The state behavioral health system, in partnership with the state Medicaid agency, expanded the array of covered services and supports by adding new service types to the Medicaid benefit and expanding service definitions of already covered services. Rates were also restructured to better correspond to system goals of encouraging increased use of home and community-based services.

Hawaii's efforts to expand their home and community-based service array, while simultaneously providing education, training, and technical assistance to shift to a home and community-based service philosophy, has significantly reduced the utilization of residential services. Child and family teams are empowered to authorize whatever services they deem necessary; access to deep-end services has not been restricted and there are no specific line items in the budget for residential vs. non-residential services. The Child and Adolescent Mental Health Division in the Department of Health bears the cost of all children's mental health treatment and with the absence of line items in the budget, dollars can follow the child from residential treatment to community-based services, as needed.

Vermont used its Medicaid Home and Community-Based Waiver as one financing component in building the system of care and expanding the home and community-based service array. The savings from reduced utilization of deep-end placements are captured and reinvested in HCBS. An evaluation of Vermont's waiver program found significant savings per child under the waiver: $150 per day compared to $1,200 per day for inpatient services.

For more information about Arizona, Hawaii, Vermont, and other states, visit:
http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/Study03-exp-fr-field.pdf

Table 2: Examples of IIHS billing codes used in various states

STATE	BILLING CODES AND MODIFIERS	UNIT
Massachusetts	■ MA level H2019 – HO ■ BA level H2019 – HN	■ 15 minutes
Michigan	■ H0036 (with modifier ST for TF-CBT)	■
Montana	■ H0040 UA	■ Per encounter (50 min minimum and one encounter per day except for participation in wraparound team meetings)
North Carolina	■ H2022	■ Per diem with 2-hr minimum

Utilization management and quality monitoring

Ensuring that the right youth receive IIHS at the right time is an important activity for states interested in delivering IIHS care. Some states such as Connecticut engage an ASO or a managed care company(s), as is the case in Massachusetts, to perform utilization management (UM) activities. Others may have state employees doing this, while some use a care management entity or wraparound teams. States need to monitor for both over *and* under-utilization of services and supports for youth with serious behavioral health challenges. Given that service dollars are finite and too much service can be intrusive and disempowering for families, careful attention must be paid to ensuring that youth and families receive the right mix of services and supports and for the right amount of time. UM approaches that call for a review of IIHS care once the youth has reached a certain dollar threshold or length of stay and/or places limits on the types of services that can be provided at the same time, which can help protect against over-utilization of IIHS. For example, Connecticut does not allow FFT to be provided at the same time as other intensive home-based services like MSFT, MST, IICAPs, or its Family Support Team service. Montana uses its child and family teams to recommend services such as IIHS based on the identified needs of the child and family, but then requires that the plan developed by the team be reviewed and approved by a regional manager employed by the state's Children's Mental Health Bureau.

Having an insufficient amount of the 'right' services and supports can be equally ineffective and lead to crises thereby thwarting important system goals such as improving youth and family functioning and decreasing costs. UM strategies that include regular reviews of data to identify youth who are high-utilizers of mobile crisis or inpatient care, and then following up with families and/or service providers to facilitate a referral to IIHS is one way system planners can monitor for under-utilization of appropriate services and supports. Use of child and family or wraparound teams who are charged with regularly reviewing if the services and supports in a plan for a child are meeting his/her needs and making adaptations as necessary is another approach to ensuring that youth have the right mix of appropriate services and supports.

In states like Massachusetts and North Carolina, IIHS teams have 24/7 urgent response capacity as a first line approach to stabilizing crises and preventing an out-of-home placement or emergency department use. When thought of in the context of UM, building this urgent response capacity into the IIHS team can also be considered an important UM function.

Ensuring that the services provided by intensive in-home teams are of high quality and are achieving good outcomes on behalf of youth and families should also be thought of as a component of a system's approach to UM. If IIHS is not delivered in accordance with expected treatment standards there is the potential for increased use of deeper end services. Ohio developed an Intensive Home-Based Fidelity

Rating Tool that rates IIHS providers on areas such as crisis response and availability, safety planning, family involvement, location of service, and supervisory support and availability. At least one fidelity review must be conducted annually by an independent source with results incorporated into the IIHS provider's performance improvement program. Massachusetts recently begin implementing a qualitative child and family review process where trained independent reviewers review the care of randomly selected youth who are participating in IIHS. Interviews are conducted with IIHS service providers, youth and family members, and other formal service providers working with the youth/family to assess how services are working "on the ground" for the youth and family. The information from these reviews is summarized with feedback regarding strengths and opportunities for improvement provided to policymakers and IIHS providers. Montana's CMHB conducts annual performance audits and quality assurance reviews to monitor adherence to the state's policies and practices and to ensure that providers are delivering IIHS in compliance with expected standards of care. Montana also collects data on service utilization, length of treatment, cost per individualized service plan, CANS assessment data, and aggregate costs as part of their overall approach to looking at quality and outcomes for youth receiving 1915(i) HCBS state plan services including IIHS.

Conclusion

By making IIHS available to youth with behavioral health challenges and their families, states can meet important goals consistent with systems of care values and principles such as keeping children in their homes and local communities, promoting access to a broad array of effective, community-based services and supports, as well as ensuring that services are offered in the least restrictive, most normative environments. Investing in IIHS also offers public purchasers the opportunity to meet important strategic financing goals such as redirecting funds from "deep-end" interventions such as psychiatric hospitals and PRTFs to community-based alternatives that have more evidence of their effectiveness. Further, developing services and supports such as IIHS that help youth live in the community can help states meet their obligations under Title II of the ADA and Medicaid's EPSDT requirements.

As described in the joint CMCS/SAMHSA informational bulletin, new opportunities developed as part of the Affordable Care Act, such as the reauthorization of the MFP Rebalancing Demonstration and the changes to the 1915(i) HCBS state plan authority, have given states more options to design benefits that can help meet the individualized needs of youth with behavioral health challenges. Leveraging these and other opportunities can assist states to implement IIHS and other HCBS that are cost-effective and have better outcomes for youth and families.

For More Information

State examples

Connecticut: http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314366

Massachusetts: http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-in-home-therapy.pdf

Michigan: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_7145-14675--,00.html

Montana: https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/FINAL915(i)HCBSProviderPolicyManualOct15.pdf

North Carolina: https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/State-Funded%20Enhanced%20MH%20SA%20Services%208-1-15-final%20for%20posting_0.pdf

Ohio: http://mha.ohio.gov/Default.aspx?tabid=200

Financing information

United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*.
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

Evidence-based practice information

Blueprints for Healthy Youth Development
http://www.blueprintsprograms.com/

The California Evidence-Based Practice Clearinghouse for Child Welfare
http://www.cebc4cw.org/

SAMHA's National Registry of Evidence-Based Practices and Programs
http://nrepp.samhsa.gov/

[1] Centers for Medicare and Medicaid Services. (2013). *National evaluation of the Medicaid Demonstration Waiver Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities: Final evaluation report* (HHSM-500-2006-000071, Task Order #2). Retrieved from: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/CBA-Evaluation-Final.pdf.

[2] Center for Mental Health Services. (2009). *The Comprehensive Community Mental Health Services for Children and their Families Program: Evaluation findings – Annual report to Congress, 2009.* Atlanta, GA: ICF International.

[3] Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). *Return on investment in systems of care for children with behavioral health challenges*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[4] Services included here were therapeutic foster care, family therapy and education, therapeutic behavioral support, behavioral management consultation, wraparound, crisis intervention and stabilization, in-home services, respite, Multisystemic Therapy, and peer support.

[5] Pires, S.A., Grimes, K.E., Allen, K.D., Gilmer, T. & Mahadevan, R.M. (2013). Examining children's behavioral health service utilization and expenditures. Hamilton, New Jersey: Center for Healthcare Strategies.

[6] http://www.ada.gov/ada_title_II.htm

[7] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

[8] United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. (2013). *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*. Retrieved from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[9] Several of the managed care entities subcontract with managed behavioral healthcare organizations that in turn contract with behavioral health providers across the state.

[10] The CAFAS is used for youth between the ages of 7-17 while the preschool version, the PECFAS is used for youth between the ages of 3-7.

[11] A qualified individual is defined as licensed mental health professional employed by the state's UR contractor who has the education and professional qualifications to enable them to complete an assessment that is specific to the 1915(i) HCBS State Plan program.