Nebraska Division of Behavioral Health

Financial Investment Blueprint for Children's Behavioral Health Services

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Introduction

The State of Nebraska (State) is committed to bettering the lives of its children through the Nebraska Children's System of Care (NeSOC). This important initiative will build on established programs to create a comprehensive and sustainable service delivery system that is youth-guided, family-driven, trauma-informed, and culturally-responsive. Its intent is to improve outcomes for children and youth with or at risk for mental health and other challenges. An important goal of the NeSOC is to eliminate the need for families to navigate multiple systems.

The priority outcomes for the NeSOC established by Governor Pete Ricketts include the following:

- Decrease the proportion of youth who report living in a setting that is not their home (i.e. foster care, jail, prison or hospital).
- Increase the number of children and youth who attend school regularly.
- Decrease costs per youth receiving services.
- Decrease in average age of first system contact.

By January 2020, the NeSOC hopes to:

- Increase the number of children and youth in the SOC who experience improved lives;
- Increase the number of children and youth in the SOC who experience improved services and supports;
- Increase the number of children and youth in the SOC who have improved educational experiences;
- Increase the number of parents and caregivers of youth in the SOC who experience improved lives;
- Enhance efficiencies in costs through the SOC; and
- Facilitate the transformation of children and youth's mental health services through the SOC.

In October 2016, the Nebraska Department of Health and Human Services (DHHS) was awarded a grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) for a sustainability and expansion project to serve children and youth with serious emotional disturbance (SED) in or at risk of out-of-home placements. This grant will provide Nebraska with federal resources that would enhance efforts to support children and youth with SED, one of the target populations for the NeSOC.

The NeSOC planning effort relied on experience from other states and communities that implemented similar initiatives and reported significant reductions in the use of inpatient psychiatric care, residential treatment, and other out-of-home placements for children involved in the justice and social services systems. Some system of care (SOC) initiatives have also

resulted in decreased use of health emergency room services. The return on investment (ROI) for these initiatives includes significant savings as well as improvement in the outcomes of care for children and families.

The DHHS Division of Behavioral Health (DBH) engaged TriWest Group, LLC (TriWest), to assist the NeSOC Project Management Team with the development of a financial investment blueprint report on mental health and substance use services (behavioral health services[1]) available to children and youth across child-serving divisions. This blueprint report is based on the information obtained from the following DHHS divisions: Behavioral Health (DBH), Children and Family Services (DCFS), and Medicaid & Long Term Care (DMLTC), with additional contributions from the Division of Developmental Disabilities (DDD) and Division of Public Health (DPH), as well as the Administrative Office of Probation, Juvenile Services (AOP JS). For the purposes of this report, the DHHS Divisions and the AOP JS may be referred to collectively as "State Entities." The Nebraska Children and Families Foundation (Nebraska Children), a private foundation supporting at-risk children, young adults, and families has joined in a public-private partnership to assist the NeSOC in managing and coordinating the implementation work teams, as well as expanding service capacity through private philanthropic partnerships.

Purpose

The purpose of this financial blueprint is to describe "what funds are being spent by whom, for what, and on behalf of which children" (throughout the document, the terms "children" and "youth" may be used interchangeably). NeSOC has the goal of redeploying funds from higher-cost to lower-cost services that are known to be more effective, while increasing flexibility within funding streams and developing funding options such as braiding funding across systems and private and foundation contributors.[2]

Medicaid represents the best option to leverage existing state dollars to obtain the most Medicaid reimbursement without increasing the overall costs to the state of Nebraska for the NeSOC.

This financial blueprint helps to identify funding sources and

[1] Behavioral health as defined by Substance Abuse and Mental Health Services Administration (SAMHSA) refers to mental/emotional well-being and/or actions that affect wellness. Behavioral health problems include substance use disorders; alcohol and drug addiction; and serious psychological distress, suicide, and mental disorders. Problems that range from unhealthy stress or subclinical conditions to diagnosable and treatable diseases such as serious mental illnesses and substance use disorders are included. The phrase "behavioral health" is also used to describe service systems that encompass prevention and promotion of emotional health; prevention of mental health and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support. See http://www.samhsa.gov/data/national-behavioral-health-quality-framework.

[2] Nebraska Department of Health and Human Services. (2016, May). *SOC expansion and sustainability FOA No. SM-16-009. May 2016 (*Unpublished federal grant application provided by DHHS), p. 25.

spending patterns on services. However, as in most states, Nebraska faces challenges in obtaining unduplicated information on service utilization by child and family across the State Entities. This is due to historical differences in funding sources, missions, financing, information systems, and reporting requirements. As a result, this financial blueprint report serves as a first step in identifying behavioral health (BH) funding sources, common as well as different services provided by the State Entities, and a high-level description of service utilization. Information on the number of Medicaid-eligible children and youth served by each State Entity, and the type of services they received through non-Medicaid funding sources, is not currently available. This information is necessary to determine the full scope of state general funds that can be leveraged to obtain Medicaid reimbursement for children and youth who are eligible for Medicaid and receiving Medicaid-covered services. There are opportunities to bill other insurances, and similar information will be needed to identify other insurance funding.

Financial Blueprint is a Pathway to Financing the NeSOC

This financial blueprint report should be considered a pathway to financing the NeSOC, leading to three additional steps:

1. *Review and clarification* – Review of the information provided by each State Entity will be necessary to add clarification and additional data that may have become available since the initial data collection request in 2015.
2. *Identify and track Medicaid eligibles by State Entity, the specific services received by Medicaid eligibles, and the current funding source for the services* – This data will provide the information necessary to determine if state general fund dollars can be leveraged to obtain Medicaid matching funds for Medicaid-eligible children receiving Medicaid-covered services. It will also allow Nebraska to determine if services not currently covered, but allowable, by Medicaid could be included in the State Plan or other Medicaid authorities. The focus of this exercise is to identify potential Medicaid reimbursements to offset state costs and maintain state budget neutrality.
3. *Implementation pathway phase* – It will also be necessary to review the financing recommendations in this report and select the specific strategies to leverage state, Medicaid, and other federal funds for BH services across the State Entities as well as review the resources from foundations, private contributions, and commercial insurers.

This report also offers recommendations for utilization of resources in ways that promote efficiencies by delivering services with the best outcomes. To facilitate implementation of the NeSOC, the recommendations in this report align with the NeSOC goals for cross-division integration and development of services, as described throughout Nebraska's application for SOC funding.

It is essential for Nebraska to achieve agreement among NeSOC partners about the financing strategies that will rely on shared resources.

Children and youth with developmental disabilities and a co-occurring mental health condition and/or a co-occurring substance use condition also benefit from specific services designed for SOC initiatives, but require special attention to address the developmental disability *and* the BH condition. While the DHHS Divisions of Developmental Disabilities and Public Health contributed to this report, in Nebraska, as in other states, it was challenging to quantify BH resources for this population. The Public Health Division provides an array of public health, prevention, and early intervention services that are population-based and tracked separately. As a result, these interventions are not easily quantifiable in terms of leveraging funding, but are important to the overall SOC.

Nebraska's educational system is an important part of the NeSOC and an invested stakeholder and participant in service planning for individual children and families, as well as a funder of critical educational services. This financial blueprint report does not include the financial contributions of local education agencies for BH interventions because of the complexities in documenting these resources and the way funding flows through local systems for these resources.

The model for this report is based on the work of Armstrong and Pires et al. with the Research and Training Center for Children's Mental Health at the University of South Florida, as well as work completed by Pires for the state of Georgia to identify financing strategies for its SOC.[3,4,5] The report was further adapted to Nebraska based on available information, the goals of the NeSOC, and TriWest's experience with designing financing and program strategies for the implementation of SOC in other states.

This report also provides strategies for collaboration with commercial insurers to promote the best care for Nebraska's children and families. Behavioral health conditions occur throughout the population regardless of income levels and education. The description of the prevalence of behavioral health conditions in Nebraska compared to national prevalence data described in the background section of this report will provide information on the rationale for working

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[3] Armstrong, M.I., Pires, S.A., McCarthy, J., Stroul, B.A., Wood, G.G., & Pizzigati, K. (2006). *A self-assessment and planning guide: Developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-01)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (FMHI Publication #235-01.)

[4] Pires, S.A. (2007). *Report on behavioral health spending for children and adolescents in Georgia across child-serving agencies.* Washington, D.C.: Human Service Collaborative.

[5] Stroul, B.A, Pires, S.A., Armstrong, M.I., McCarthy, J., Pizzigati, K., Wood, G.G., McNiesh, R., & Echo-Hawk, H. (2009). *Effective financing strategies for systems of care; Examples from the field, second edition.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health.

collaboratively with insurers to identify and provide early treatment for children and families.

Rationale for Leveraging State, Federal and Private Funding and Other Insurance

Using state dollars to leverage Medicaid, the use of Title IV-E funds (foster care), and federal block grants, as well as tapping private funding and other insurance, are pathways to sustainable funding for the full implementation of the NeSOC. It is important to note that not every child/youth in the NeSOC will be eligible for Medicaid, but when they are eligible, it is important to obtain Medicaid reimbursement to reserve some state dollars for uninsured youth and for services that cannot be covered by Medicaid or other federal funds but are essential to obtaining better outcomes and decreasing overall costs.

Nebraska's Approach and System of Care (SOC) Initiatives

The NeSOC focuses on creating a broad system of care for all children regardless of funding source, with a special focus on addressing the needs of children and youth with behavioral health challenges who are at risk of out-of-home placements, involved in multiple child-serving systems, and/or are of transition age (16 to 21 years) and not already involved in a transition-age program. This initiative also targets the creation of a statewide crisis response system (a recognized gap in the state's child-serving systems); enhanced family engagement in services planning; enhanced peer support services; recognition and integration of racial, ethnic, and cultural needs into services planning; and enhanced cross-system and local service and support planning for consumers that frequently use high-cost services.[6]

In Region 3, by focusing on wraparound care coordination and community-based services, the average cost per family served was 60% less than the cost of those served through out-of-home services.[6]

In Region 3, Nebraska has already demonstrated a significant return on investment (ROI) by reducing the use of restrictive care models from 2001 to 2009.

The strategies used nationally in the SOC model tend to improve services for all children through:

- Emphasis on family and youth-driven treatment plans;
- Improved cross-division information sharing protocols;
- Use of standardized screening and assessment tools and, when relevant, a single service plan across providers and State Entities;
- Access to a greater array of evidence-based practices (EBPs), promising practices (PPs), and other services with good outcomes;

[6] Nebraska Department of Health and Human Services. (2016, May). *SOC expansion and sustainability FOA No. SM-16-009. (*Unpublished federal grant application provided by DHHS).

- Statewide training on important topics such as the impact of trauma on children and families and the treatment of co-occurring mental health and substance use conditions;
- Emphasis on clinical criteria designed to individualize treatment and supports;
- Development of prevention and early intervention protocols; and
- Overall attention to the children's service delivery system.

With the NeSOC, Nebraska has the opportunity to braid the funding of these initiatives to create a cross-division child-serving system.

Another major state initiative, Legislative Bill 561, passed in May of 2013, charged the Nebraska AOP JS to treat and rehabilitate court-involved youth, a portion of whom have significant behavioral health challenges.[7] Also in 2013, DCFS obtained a Title IV-E waiver to allow implementation of the *Alternative Response* (AR) model as an alternative pathway for families instead of traditional child protective services (CPS) investigations. This model allows families to stay together when children can safely remain at home through the provision of in-home services and supports tailored to the needs of the child's family.[8]

Goals of these three major initiatives include developing alternatives to out-of-home placements through provision of home- and community-based services and bringing children living in out-of-state placements back home to Nebraska.

The implementation of the NeSOC, the Title IV-E Alternative Response model, and changes reframing probation interventions into treatment and rehabilitation rather than supervision, are significant undertakings and require the use of practices that have demonstrated effectiveness. DHHS and AOP JS have experience with the implementation of EBPs and PPs, which is an essential component of a SOC.

Federal Funding for Evidence-Based and Promising Practices

Rules for federal financing, particularly in recent years, allow states to pay for EBPs and PPs that have better outcomes than services that do not meet the standards of various research-based programs. Recognizing the positive outcomes of EBPs and PPs, the Substance Abuse and Mental Health Administration (SAMHSA), the Administration for Families and Children, and the Centers for Medicare and Medicaid Services (CMS) have promoted and provided the funding for research-based services models.

[7] See description of LB 561 at https://supremecourt.nebraska.gov/10824/juvenile-services.
[8] Department of Health and Human Services, Administration for Children and Families Administration on Children, Youth and Families Children's Bureau. (n.d.). *Title IV-E Waiver Authority, Nebraska*. Retrieved on June 10, 2016 from http://dhhs.ne.gov/children_family_services/Documents/WaiverTermsandCond.pdf.

SAMHSA block grants provide an important funding stream for services for individuals not covered by Medicaid and are often used for indigent individuals and families. Grant opportunities such as SOC planning and implementation grants provide states with funding to apply proven practices to each state's unique circumstances.

CMS has provided the authority to use Medicaid funds for services not traditionally covered by other insurance plans. It is now possible to leverage Medicaid for a wider array of EBPs and PPs by utilizing opportunities within Medicaid State Plan and waiver authorities. Use of EBPs and PPs will allow Nebraska to capitalize on the many advances in the delivery of behavioral health services over the past two decades by providing services that have the best outcomes.

While Nebraska has already taken steps within Medicaid to allow for the provision of specific research-based practices, there are other opportunities to leverage Medicaid funding under existing rules to strengthen the array of reimbursable services for children and families while controlling costs.

This is not an expansion of Medicaid, but rather a utilization of proven practices for high cost services that may not have the best outcomes under a traditional medical model.

The NeSOC and research-based practices already in use by DBH, such as Parent Child Interaction Therapy (PCIT) and Wraparound (a child and family-driven form of care management), and by DCFS for the Alternative Response, such as the Positive Parenting Program (Triple P), PCIT, and Wraparound, are positive examples of services with the best outcomes.[9,10,11] The AOP JS has adopted the Crossover Youth Practice Model (CYPM), developed by Georgetown University, which reduces the number of youth who "crossover" between the child welfare and juvenile justice systems, and the Juvenile Detention Alternatives Initiative (JDAI), a project of the Annie E. Casey Foundation, which has demonstrated that jurisdictions can safely provide medical and psychosocial interventions and reduce the use of secure confinement without impacting public safety.

These initiatives form the basis for further leveraging Medicaid funds because they emphasize the provision of EBPs and PPs that are covered by Medicaid, state dollars, and other federal funding to maximize access to services for children and families. For example, while detention center services are not reimbursable under Medicaid, family- and home-based treatment interventions are. A range of research-based, in-home alternatives to psychiatric residential treatment facilities (PRTFs) and inpatient psychiatric care can be funded through Medicaid.

[9] See Parent Child Interaction Therapy at http://www.pcit.org/.
[10] See Positive Parenting Program at http://www.triplep.net/glo-en/home/.
[11] See the National Wraparound Initiative at http://nwi.pdx.edu/wraparound-basics/.

Foundations/Private Funding

The Nebraska Children and Families Foundation (Nebraska Children) is a private foundation supporting Nebraska's children, young adults, and families at risk, with the overall goal of giving the state's most vulnerable children what they need to reach their full potential. Nebraska Children provides funding throughout the state (which will be described later in this report) and also has agreed to enter into a public-private partnership with DHHS to help the NeSOC management with a variety of tasks related to implementation, communications, and engaging youth in planning. Nebraska Children will also contribute to the state's match requirement for the federal SOC grant application. Other foundations, such as the Sherwood Foundation, which supports a two-generation impact approach, contributed start-up funds for AOP JS implementation of Multisystemic Therapy (MST), an important alternative to out-of-home placement. These funds paid for training and ongoing fidelity assessment to practice standards. Providers also rely on private donations from individuals and organizations, which has been a long tradition in Nebraska and important in financing various services.

Commercial Insurance

Since 1999, with the passage of Revised Statute 44-791, Nebraska has recognized the importance of treating mental health conditions through commercially insured group health plans by requiring coverage of mental health services.[12] This legislation promotes the understanding that individuals with mental health conditions can and do lead full and productive lives, but without treatment or management, these conditions can progressively deteriorate and negatively impact a person's livelihood, social relationships, and physical health.[13] Untreated mental illness and substance use disorders also result in greater overall health care costs. A national study found that individuals with behavioral health conditions have two to three times higher healthcare costs ($1,085 versus $397 per member per month), with the greater proportion of additional cost for physical health needs, not behavioral health needs.[14]

Kessler et al. found that about half of Americans will experience a mental illness at some point in their lives, with first onset in childhood or adolescence, concluding that early treatment and prevention should focus on youth. This research identified the mean age for early onset of anxiety and impulse disorders was age 11 years, with much younger children experiencing

[12] See Chapter 44 Section 791 at http://www.nebraskalegislature.gov/laws/statutes.php?statute=44-791

[13] Nebraska Revised Statute 44-791, accessed on June 8, 2016 at http://www.nebraskalegislature.gov/laws/statutes.php?statute=44-791.

[14] Melek, S.P., Norris, D.T., & Paulus, J. (2014, April). *Economic impact of integrated medical-behavioral healthcare: Implications for psychiatry*. Denver, CO: Milliman, Inc. Retrieved on May 1 2016 from https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf.

these disorders. Half of all mental disorders start by age 14 years and three fourths by age 24 years.[15]

There are significant opportunities to work collaboratively with commercial insurers (in addition to Medicaid health plans) to promote the use of cost-effective EBPs and PPs for children and families, particularly related to early intervention and screening by primary care physicians. For example, the evidence related to early screening, assessment, and treatment of BH conditions finds that services implemented with fidelity to best practice standards not only decrease the cost of BH care, but also the costs of healthcare, abuse and neglect, and other societal costs. The cost offsets related to early and effective treatment of BH conditions suggest that payment (by public and commercial insurers) of early screening and identification of BH conditions in primary care settings could lead to earlier treatment. [16, 17] This is an especially relevant opportunity for Nebraskans in light of the identification of a high-risk population of youth aged 12 to 20 years who are engaged in underage drinking.[18]

The Institute of Medicine and the National Research Council found a cost-benefit ratio of one (1) dollar of investment in early treatment and prevention programs for addictions and mental illness resulted in two (2) to 10 dollars in savings across health, criminal and juvenile justice, and educational costs, as well as lost productivity.[19] Leveraging the resources of commercial health insurers to reduce healthcare costs and improve health outcomes for all Nebraskans, including those insured by private insurance as well as those using public resources, is a significant financial opportunity.

The cost offsets related to early and effective treatment of BH conditions suggest that payment for early screening and identification of BH conditions in primary care settings could lead to earlier engagement in treatment.

Importance of Access to Early Childhood Mental Health Across all Payers

Early childhood mental health (ECMH), which focuses on infants and toddlers, is especially

[15] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005, June). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*. Retrieved on June 6, 2016 from http://www.ph.ucla.edu/epi/faculty/detels/PH150/Kessler_DSMIV_AGP2009.pdf.

[16] Mrazek, D.A., Hornberger, J.C., Altar, C.A., & Degtiar, I. (2014). A review of the clinical, economic and societal burden of treatment-resistant depression, 1996-2013. *Psychiatric Services*, *65*(8).

[17] Foster, E.M., Prinz, R.J., Sanders, M.R. & Shapiro, C.J. (2008). The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*, *30*(5), 493-501.

[18] Nebraska Department of Health and Human Services. (2016, May). *SOC expansion and sustainability FOA No. SM-16-009. May 2016 (*Unpublished federal grant application provided by DHHS), p. 28.

[19] O'Connell, M.E., Boat, T, & Warner, K.E. (Eds.) (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press.

important as a prevention strategy. ECMH promotes healthy relationships between young children and their parents as well as age appropriate social and emotional behaviors for all young children, especially for those whose life experiences place them at the greatest risk.[20] Parenting programs and education of caregivers about effective parenting are important components of behavioral health care and should be supported by all public and private funders to promote population health and cost efficiencies.

Educators, pediatricians, early intervention providers, and schools, as well as public health and social service organizations that assist parents with infant and toddler care, require financial support to provide health/behavioral health education, referrals, and treatment. This support is crucial to the provision of effective interventions, such as those provided by public health nurses, including education on positive social and emotional development and home visits following the birth of a child, which offer opportunities to prevent maltreatment and trauma, and address parenting problems. EBPs such as The Incredible Years,[21] the Triple P (Positive Parenting Program),[22] and Raising a Thinking Child[23] are examples of therapeutic educational interventions that assist parents with raising healthy infants and toddlers. When specific problem areas are identified, treatment interventions such as Child Parent Psychotherapy (CPP)[24] and Parent Child Interaction Therapy (PCIT)[25] are available to help parents and their

The importance of social services and mental health organizations partnering with educators and early intervention programs is essential to foster prevention and early treatment.

[20] Johnson, K., Knitzer. (2005). *Spending smarter: A funding guide for policy makers and advocates to promote social and emotional health and school readiness.* New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.

[21] The Incredible Years® is a series of interlocking, evidence-based programs for parents, children, and teachers, supported by over 30 years of research. The goal is to prevent and treat young children's behavior problems and promote their social, emotional, and academic competence. The programs are used worldwide in schools and mental health centers, and have been shown to work across cultures and socioeconomic groups. Available at: http://incredibleyears.com/.

[22] The Triple P – Positive Parenting Program is one of the most effective evidence-based parenting programs in the world, backed up by more than 30 years of ongoing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's behavior, prevent problems from developing, and build strong, healthy relationships. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups, and in many different kinds of family structures. Available at: www. triplep.net.

[23] Information available at: http://www.thinkingchild.com/.

[24] Child-parent psychotherapy integrates a focus on the way the trauma has affected the parent-child relationship and the family's connection to their culture and cultural beliefs, spirituality, intergenerational transmission of trauma, historical trauma, immigration experiences, parenting practices, and traditional cultural values. Information available from the National Child Traumatic Stress Network at: http://www.nctsn.org/sites/default/files/assets/pdfs/cpp_general.pdf.

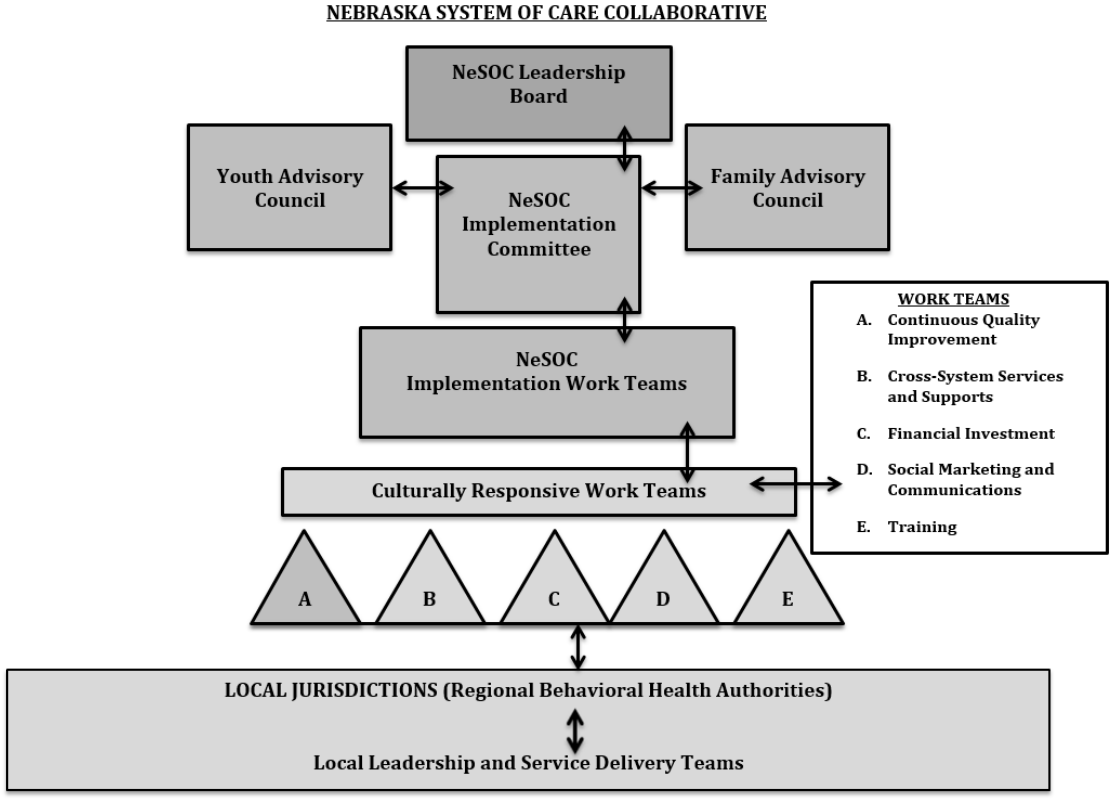
[25] Parent-child interaction therapy (PCIT) is an evidence-based treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Available at: http://www.pcit.org/.

children effectively addressing more pressing needs. SOC collaboration with early intervention and education programs is essential to implementing these research-based practices.

Overview of the NeSOC Structure

The strategic planning process for the NeSOC identifies the NeSOC Collaborative as the partnership that will design and implement the SOC at all levels – local, regional, and central. This collaborative includes equal partnerships among youth, family, and system partners, including the State Entities. There is a SOC Leadership Board that will operate under the leadership of the DHHS CEO, and a SOC Implementation Committee that will be led by the DBH SOC Administrator with guidance from the Youth and Family Advisory Councils. Standing SOC work teams will focus on continual quality improvement, cross-system services and supports, financial investment, social marketing and communications, and training. Culturally responsive work teams will interact with stakeholders throughout the planning and implementation process. The DBH Regional Behavioral Health Authorities (RHBAs) will manage the SOC in local jurisdictions, working with local leadership and service delivery teams. Figure 1 below, depicts the organizational structure and planning teams.[26]

Figure 1. NeSOC Collaborative Organizational Structure



[26] Nebraska Department of Health and Human Services. (2016, May). *SOC Expansion and Sustainability FOA No. SM-16-009. (*Unpublished federal grant application provided by DHHS), p. 12.

This collaborative organizational structure reflects similar approaches in other states where TriWest has worked to implement SOC collaboratives and highlights the need for extensive input from system partners. The next section of this report will provide a summary of findings and recommendations pertaining to the overarching goals identified in the NeSOC federal grant application and informed by TriWest's assessment of the information provided by the State Entities. As noted on Figure 1 above, the six (6) DBH Regional Behavioral Health Authorities (RBHAs) will serve as the state's local jurisdictions for SOC implementation.

Cross System Findings and Recommendations

The findings and recommendations in this section of the financial blueprint are organized to support the NeSOC priorities for system change described in the federal grant application.

A. Creating a Sustainable Financial Infrastructure for the NeSOC. (SOC Expansion and Sustainability FOA No. Sm-16-009, page 9)

Strengths

Finding A-1. The organization of the NeSOC Collaborative, the SOC Leadership Board, the Youth/ Family Advisory Committee, the SOC Implementation Committee, and the discrete roles and responsibilities of the culturally responsive work teams provides a good foundation on which to build an infrastructure. In particular, it is notable that the Financial Investment Workgroup includes clinical representatives. The inclusion of both clinical and financial participants on this committee is a strength when designing clinical services and supports, and particularly when the services must be financed across multiple funding agents with different rules and regulations. We interpret this as an intentional approach to define and use the evidence-based practices (EBPs) and promising practices (PPs) that have the best outcomes and are cost effective. Collaboration between the clinical and financial staff is essential to achieve the NeSOC goals.

Finding A-2. The approach to development of the NeSOC has occurred over time in a thoughtful, planned manner. State Entities and providers have already piloted the use of Wraparound and other EBPs and PPs such as Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), and Child-Parent Psychotherapy (CPP). There is broad recognition of the need to develop the NeSOC and understanding of the steps required for implementation.

Opportunities

Finding A-1. Currently, the State Entities each contract and reimburse providers for the same or similar services, depending on their funding source. Medicaid has a separate infrastructure. The financing infrastructure for managing braided funding payments is complex and requires attention from the beginning of the planning process. Braided funding opportunities are optimal but complicated and require the technical knowledge and capabilities needed to authorize and make payments that are consistent with the rules and reporting requirements of various funding sources. For this reason, some states have used behavioral health organizations (BHOs), third party administrators (TPAs), or the Medicaid Management Information System (MMIS) to pay providers for braided services. The entity that processes payments must understand the rules (e.g., Medicaid, Title IV-E, block grants, etc.) that specify who is eligible for the funding stream, what services are covered by the funding agent, and

which providers are authorized (licensed, certified or otherwise credentialed) to provide the services. Once the rules are clear, the information, reporting, and payments systems should be able to support the authorization and payment process. This usually requires planning at least a year in advance of implementation. While the delivery system must be close to the child and family to be effective, the supporting administrative structure must be standardized statewide and have the capacity to address authorization, funding, and reporting in order to optimize funding streams.

Recommendations

Recommendation A-1. Establish a subgroup of the Financial Investment Workgroup to determine the flow of funding, payment mechanisms, rates, and information systems needed to manage authorizations, payments, and reporting. The NeSOC must consider whether funding will be transferred from each State Entity to one organization that will administer the funding, or if each organization will hold the funds, reimburse providers directly, or reimburse a funding agent to pay the provider when payment of the service is one of the partner's responsibility. This is one of the most technically challenging areas in administering SOC funding because of the complexities of funding source requirements and reporting needs. The subgroup should include representatives knowledgeable about the funding source prohibitions (especially Medicaid and Title IV-E), allowable services, eligible children and families, billing rates and documentation requirements, and existing and proposed information systems (IS) that manage payments from each partner. Rules regarding who is allowed to authorize the payment will also need to be developed and built into the process and information systems. A sample flow chart outlining the flow from intake to payment is included as Appendix One.

Recommendation A-2. Develop a protocol for determining financial responsibility for payment of services that is consistent with the flow of funding, payment mechanisms, and information systems needed to manage payments. The NeSOC will need to articulate a protocol or flowchart (see sample in Appendix One) that is agreed to by all payers, memorialized in a Memorandum of Understanding or similar document that is thoroughly vetted, and matches the operating systems and instructions for processing payments. There will likely be differences of opinion about "who pays for what." While not every potential payment rule can be determined in advance, it is useful to have a protocol that outlines a hierarchy of payments that utilizes private insurance and Medicare prior to Medicaid, followed by other entitlement funding and block grants, with the use of state and local funding as a last resort. This protocol should also detail how decisions will be made when a difference of opinion about payment responsibility occurs.

Recommendation A-3. Pay the same rates for the same service across the NeSOC service array. If an additional service element is required based on the needs of the child/youth, or if regulations require a specific type of intervention, pay for the additional intervention

separately. While all children/youth have individualized needs, paying different rates for the same service can result in the creation of inadvertent financial incentives throughout the system where some children are prioritized over others. It can also result in overpaying for some services and underpaying for others as well as encourage referrals through the State Entity that pays a higher rate for a service or assessment. We recommend that the Financial Investment Workgroup assess how to handle standardizing rates for the same services across State Entities. When the State Entities have distinct services that are called the same name (e.g., residential program), it is important to clearly differentiate the services so that all parties understand the service definition, the scope of services, staffing, and goals of the service. When this differentiation occurs, there may be different rates. For example, if a program targets youth who have sexual offenses or behaviors, this program may need a higher level of staff intensity and training, which may require a different rate than another type of service.

B. Changing the paradigm of utilization patterns and expenditures from high-cost restrictive services to more cost-effective home- and community-based services and supports. (Grant application page 10)

Strengths

Finding B-1. The Nebraska State Entities have taken strong steps to align their missions to promote family-driven and community-based services, emphasizing the inherent strengths of families and communities and promoting recovery and resiliency. Each of the State Entity representatives who offered information for the financial blueprint all consistently addressed the need to increase in-home, family- and community-based services for children/youth, and reported movement in a positive direction away from the most restrictive and costly services, such as psychiatric residential treatment facilities (PRTFs), youth detention, and inpatient care. The consistency of the effort and discussions among the State Entities demonstrates a positive environment to effect change.

Finding B-2: The NeSOC design and implementation focuses on the delivery of EBPs and PPs that are essential components of a SOC. The commitment of each DHHS partner is clearly identified and summarized in tables 36 and 37 that were prepared for the SOC Grant application (pp. 30-31). These tables are included in Appendix Two. This information is important and provides a good foundation for understanding and further defining roles and responsibilities, especially related to future funding and payment mechanisms.

Opportunities

The following findings target opportunities to change the utilization patterns from high-cost restrictive services to more effective and efficient family- and community-based interventions.

Finding B-3. Under the existing Medicaid State Plan, Medicaid authority could be available for EBPs and PPs proposed by the NeSOC as well as other services with good outcomes that could be covered by Medicaid for medically eligible children and youth. Prior to 2015, the State Plan permitted the Medicaid Division to implement prior authorization of EBPs that required ongoing fidelity reviews. However, it appears that the language for EBPs was removed in 2015.[27] Similar language for EPBs and other effective practices should be reinserted. The NeSOC should work with the Medicaid Division to ensure that the coding for EBPs and other effective practices is outlined appropriately for providers, and that a fee schedule is created to support the sustainability of delivering effective practices by including ongoing training, certification, and fidelity monitoring costs into the Medicaid rates.[28] This may require a State Plan amendment updating the reimbursement section of the State Plan as well as reinserting the EBP language in the State Plan.

The EBPs and PPs identified by the NeSOC planning process include services that can reasonably be expected to shift service delivery from repeat utilization of high-cost services to services that, when matched appropriately with children and families, yield outcomes that reduce reliance on the service delivery system. Nebraska Medicaid should continually assess if it has all the procedures in place to finance new or other existing EBPs that may result in good outcomes and reduce the overall costs of care.

Fidelity to Practice Models

To achieve the desired outcomes and efficiencies of using EBPs and PPs, these services must be implemented with fidelity to the practice models. Typically, this requires training on the model, certification (in some cases), and ongoing fidelity assessments to determine if the practice is consistent with the model's standards and provide ongoing monitoring of outcomes. It is essential to determine how the costs of the training, certification (if required), and fidelity monitoring will be addressed to ensure financial sustainability of cost-effective community-

[27] State Plan Amendment 11-10 states: "Medicaid and/or its designee shall prior authorize the number of hours of treatment per client need and periodically review the medical need for continued treatment of services. For the purposes of this section, the Medicaid agency designee will be a contractor designated by the agency to conduct prior authorization and utilization review. This prior authorization includes Evidence-based Practices (EBPs), which require fidelity reviews on an on-going basis as determined necessary by Medicaid and/or its designee." State Plan Amendment 08-07 states: "All services have an initial authorization level of benefit. Prior authorization is required prior to service delivery for medically necessary outpatient psychotherapy services which exceed the limitation of the initial authorization…. A unit of service is defined according to the CPT and HCPCS approved code set unless otherwise specified." SPA 00-13 appears to have removed the EBP language for EPSDT from the State Plan that would have authorized MST and FFT.

[28] Not all EBPs require separate coding and rates. For example, beyond initial training, cognitive-behavioral therapy (CBT) does not have on-going certification and fidelity costs and can be incorporated into existing rates and coding. However, FFT and MST are examples of services requiring additional coding and rate work because of the costs to the teams of maintaining fidelity. Without higher rates for these cost-effective services, providers are unable to sustain the practices in the long term.

based EBPs. These costs can be built into Medicaid payment rates or handled separately through funding of training, certification, and fidelity reviews.

Types of Evidence for Evidence-Based Practices

It is important to note the different types of "evidence" that can inform "evidence-based" decision-making, which may include provision of services that are not necessarily formal EBPs or PPs, but nevertheless have good outcomes and provide ongoing information about the effectiveness of various interventions. Evidence from the body of general services research links specific programs and approaches to outcomes for specific groups of youth for specific problems, and leads to a fairly simplistic approach to EBPs: "problem A gets treatment B."

Causal mechanism research, for example, seeks to understand factors underlying criminogenic behavior for youth involved in the juvenile justice system. Also in juvenile justice, the risk assessment approach yields evidence that comes from this body of research. Local evidence, or "practice-based" evidence reflects the beliefs and experiences of a community with programs and interventions that have been effective in that context.

Finally, case-specific information is a form of evidence that reflects data about a specific youth and family that can help match youth with programs and treatments that will motivate, engage, and support change for that youth. A broad perspective on EBPs and PPs recognizes and attempts to integrate all of these forms of evidence. This approach is ultimately both programmatic and comprehensive in its consideration of what constitutes an "evidence base." Thus, it is important to adopt a comprehensive approach to defining "evidence" so as not to inhibit the delivery of effective services.

Table 1 on the following page outlines the EBPs and PPs that will be implemented statewide for the NeSOC as identified in the federal SOC Expansion and Sustainability Grant for children and youth with serious emotional disturbances (SEDs). Many of these same services can provide assistance to the broader population that will be served through the NeSOC.

Table 1. NeSOC Evidence-Based Practices and Promising Practices Targeted for Expansion

Mental Health Services[29]	Evidence-Based & Promising Practices
Outpatient Services: These services include individual and group counseling services, professional consultation, and review and management of medications	• Parent-Child Interaction Therapy • Family-Integrated Multisystemic Therapy • Trauma-Focused Cognitive Behavioral Therapy • Child-Parent Psychotherapy • Functional Family Therapy • Motivational Interviewing • Dialectical Behavior Therapy • Eye Movement Desensitization and Reprocessing
Intensive Home-Based Services	• Wraparound (Promising Practice) • Family-Integrated Multisystemic Therapy • Functional Family Treatment
Recovery Services	• Parent-Child Interaction Therapy • Wellness Recovery Action Plan

The following table (Table 2) lists the mental health and substance abuse services financed by Medicaid for children and youth as listed on the adolescents (from ages 0 to 20 years) page of the Medicaid website and updated to include staff qualifications identified in the Nebraska State Plan and amendments.

Table 2. Covered Medicaid Services for Children and Youth

Behavioral Health Level of Care	Services
Middle Intensity Services: These services are designed to prevent hospitalization or to help a hospitalized client learn to function within the community with less frequent contact with the mental health or substance abuse provider.	• Professional Resource Family Care/therapeutic foster care • Therapeutic group homes • Crisis stabilization
Hospital Services	• Inpatient mental health services • Psychiatric Residential Treatment Facilities (PRTF) • 23-hour observation beds

[29] This is not an all- inclusive list of EBP therapies.

Behavioral Health Level of Care	Services
Outpatient Services: Services provided by a psychiatrist, psychologist, licensed independent mental health practitioner (LIMHP), and licensed mental health practitioner (under supervision of an allowable Medicaid Supervising Practitioner), and advanced practice registered nurse (APRN)	Evaluation by a psychiatrist, psychologist; Child-Parent Therapy (CPP); Eye Movement Desensitization and Reprocessing (EMDR); Functional Family Therapy (FFT); Multisystemic Therapy (MST); Parent-Child Interaction Therapy (PCIT); individual group and family psychotherapy; individual, group, and family substance abuse counseling; family assessment; conferences with family or other responsible persons; mileage (if applicable) for home-based family therapy; community treatment aid services; day treatment, intensive outpatient services; medication checks; treatment crisis intervention services.

State Procedures to Implement EBPs

Current EBPs already covered through the State Plan include Child-Parent Therapy (CPP), Eye Movement Desensitization and Reprocessing (EMDR), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Parent-Child Interaction Therapy (PCIT). These are an important and impressive array. While many of the components of the EBPs and PPs desired by the NeSOC are listed in the State Plan, it is critical to make sure that state Medicaid regulations and manuals are modified to permit payment for these services. For example, the State Plan allows reimbursement for all services within the scope of practice of a physician, psychologist, licensed independent mental health practitioner, and licensed mental health practitioner. For children, the State Plan also permits reimbursement for all services within the scope of practice of a licensed alcohol and drug counselor.

Nebraska would need to analyze the current coding and fee schedules to determine what additional guidance is needed to ensure Medicaid reimbursement. This may require an amendment to the reimbursement section of the Rehabilitation Authority of the State Plan.

Analysis of Current Nebraska Medicaid State Plan and other Funding for NeSOC Services

Crisis intervention services in Nebraska have specific codes, including mobile services, authorized under the State Plan. The availability of 23-hour observation beds covered by the current Nebraska State Plan is also an important part of the crisis system.

It is not uncommon for states to develop Medicaid State Plans that have the flexibility to reimburse EBPs and PPs, but do not have the operational systems, such as the bill codes and modifiers, to allow for authorization, payment, and tracking of service utilization and outcomes.

Crisis stabilization services are currently available under Medicaid. Facility-based residential crisis services offer crisis stabilization treatment services in a safe, structured setting for substance use or mental health conditions. The service provides continuous 24-hour observation and supervision up to 72 hours for individuals who do not require assessment and treatment in an acute inpatient hospital setting. In addition, the service provides short-term stabilization, which includes assessment, care management, medication management, and mobilization of family support and community resources. Room and board are not included in this reimbursement.

Crisis respite, a component of a full crisis continuum is missing from the current crisis system. Additional authority would be needed to reimburse for this service, which is outside of 1905(a) of the Social Security Act and requires an HCBS waiver authority. Crisis respite could be funded under various Medicaid authorities such as a 1915(c) Medicaid Home and Community Based (HCBS) waiver, a 1915(i) HCBS State Plan program option or through an 1115 demonstration waiver. Under these authorities, limited Medicaid reimbursement for room and board is permitted. Nebraska would need an appropriation to be able to apply for a 1915(c) waiver and the crisis respite settings would need to be in compliance with the HCBS final rule to obtain CMS approval of the waiver authority.

The State Plan prior to 2015 had authorization for EBPs, but apparently, the language allowing for their use was removed when the State Plan was amended to remove prior authorization language. General language allowing the use of EPBs and other effective services should be reinserted with a modification to the reimbursement authority. These services reduce out-of-home placements at the most restrictive level of care (inpatient and psychiatric residential treatment centers), and can prevent placements in group homes.

It appears that Nebraska already has the flexibility to provide other EBPs not only under its State Plan and EPSDT, as was mentioned in the Legislature's Health and Human Services Committee Hearing on March 4, 2015, but also by using current State Plan services and billing for "component" services provided for family therapy, community treatment aides, family conferences, etc. A simple amendment for coding and rates would be easier and more efficient for providers to offer a specific EBP and have one associated rate for the services. If the EBP does not require ongoing fidelity reviews or certification, there is no need for specific reimbursement authority. For example, use of motivational interviewing or dialectical behavior therapy does not require a separate service definition and bill code or modifier if it fits within a definition of a covered benefit in outpatient and inpatient settings, unless the state wishes to pay a differential rate justified by higher ongoing costs to the provider as an incentive to implement or track the practice.

While not identified in Nebraska as Medicaid-funded, wraparound care coordination activities and service planning are reimbursable under Medicaid in other states. Use of state dollars,

foundation contributions, and federal grant funding are important start-up resources for these services and can support training and fidelity monitoring. However, the long-term sustainability of Wraparound will likely need to rely on Medicaid financing for Medicaid-eligible children and youth. Other states have funded Wraparound through various Medicaid authorities through State Plan targeted case management, 1915(i) State Plan amendments, 1915 (b) and (c) waivers, and 1115 demonstration waivers, once they obtained state appropriations and identified HCBS compliant providers. Provider participation in service planning is also funded if proper Medicaid billing guidance and operational controls are implemented. In Nebraska, the State Plan service that would appear to cover provider participation is "conference with family or other responsible persons."[30] Adding Wraparound would not constitute an expansion of Medicaid; it would be a provision of a care coordination function that supports the delivery of more cost-effective services.

Family peer support is available as a state-funded service through DBH and DCFS. While the presence of family organizations in the regions strengthens the opportunities for the delivery of family peer support, it does not appear that these organizations currently have the technical and administrative capacity to bill Medicaid. The family organizations are working with DBH and DCFS to increase their administrative capabilities. Phasing in Medicaid payment for family peer support and navigation services will be important to their long-term sustainability.

In addition to these findings, recent guidance from CMS and SAMHSA pertaining to Medicaid financing and best practices provides additional financing opportunities for NeSOC. For example, the Nebraska First Episode Psychosis Coordinated Specialty Care (CSC) Pilot Program, already being implemented in two of six regions in Nebraska through the Mental Health Block Grant 5% set-aside requirement, is covered by Medicaid for Medicaid-eligible youth. This pilot program is based on the OnTrackNY Model and repurposes existing services and providers into an integrated team-based CSC program. Medicaid is already part of this pilot and financing covered service components for Medicaid eligible youth. It will be important to make sure that all Medicaid-covered services in these pilot programs are billed to Medicaid to maximize this resource. The outcomes of this program, based on early identification and intervention, prevent escalating costs during the lifetime of youth who receive these interventions.

We have highlighted three federal guidance bulletins below to assist the NeSOC planning teams with obtaining Medicaid to offset state costs. For the Financial Investment Workgroup's review, we have provided a summary of other applicable federal guidance in Appendix Three.

- **Joint Information Bulletin, October 16, 2015, CMS, the National Institute of Mental**

[30] Simmons, D., Pires, S.A., Hendricks, T., & Lipper, J. (2014). *Intensive care coordination using high-quality Wraparound for children with serious behavioral health needs*. Center for Health Care Strategies.

Health (NIMH) and SAMHSA on Coverage of Early Intervention Services for First Episode Psychosis.[31] This bulletin discusses the design of benefit packages for youth with first episode psychosis and notes: "Untreated psychosis increases a person's risk for suicide, involuntary emergency care, and poor clinical outcomes. Often individuals experience long periods of untreated psychosis and treatment delays are between one and three years following the onset of psychotic symptoms. …Early intervention can alter this illness trajectory and enable individuals …to live in community settings and participate fully in family and community life."

The bulletin continues to describe integrated, team-based mental health services that reduce the severity of first episode psychosis symptoms to a level where individuals are able to remain in school or employment. The team-based model, Recovery After an Initial Schizophrenia Episode (RAISE), was used in NIMH research to develop, test, and implement Coordinated Special Care (CSC) programs for use in actual community clinics. The research found that participants in CSC had great improvements in total symptoms, social functioning, work or school, and overall quality of life. This is an important finding, especially for older adolescents and young adults, who are at the age when the first onset of schizophrenia tends to occur. The treatment elements are consistent with many recovery-oriented services for adults and include team based care, recovery-oriented psychotherapy, family psychoeducation and support, supported employment services, supported education services, pharmacotherapy and primary care coordination, and case management.

Guidance from the bulletin discusses Medicaid reimbursements for these services, including 1904(a) authority under the State Plan; use of other licensed practitioner authority (1905 (a)(6) services); preventative and rehabilitation services (section 1905(a)(13)(c) and (d)); and section 1905 (a)(19) (as defined in section 1915(g)(2) – case management services). These services will need to be configured similar to Assertive Community Treatment (ACT). In addition, targeted case management, prescription drugs, and EPSDT benefits can support these services. Home and Community-Based Services authorities (1915 (c), 1915 (i) and 1115 waivers) allow states to design community-based services for individuals who meet an institutional level of care, as long as the community-based services do not cost more than institutional services (i.e., cost neutrality). Use of these Medicaid authorities does not constitute an expansion of Medicaid. Rather, it realigns services that have proven outcomes for a specific

[31] Wachino, V., Insel, T., & Enomoto, K. (2015, October 16). *Joint information bulletin: Coverage of early intervention services for first episode psychosis.* The Center for Medicaid and CHIP Services, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.

population. With the right combination of authorities, treatment for first episode psychosis can be targeted to older adolescents and young adults.

- **CMCS Informational Bulletin. May 11, 2016. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children.** This bulletin provides guidance for state Medicaid agencies to assist them in covering maternal depression screening as part of a well-child visit, even when the mother is not eligible for Medicaid. Because maternal depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit, which reiterates that states must cover any medically necessary treatment for the child. Due to the prevalence of maternal depression (40 to 60 percent of low-income women have some type of depression),[32] [33] and its significant early risk to child development, the mother-infant bond, and the family, Medicaid may pay for depression screening. The bulletin cites the American Academy of Pediatrics and indicates that screening mothers for maternal depression is a best practice for primary care pediatricians caring for infants and their families, and can be integrated into the well-child care schedule and the prenatal visit.

  If the screening for depression is positive, diagnostic and treatment services directed solely at the mother would be covered under Medicaid if the mother is eligible for Medicaid. However, mothers who are not Medicaid-eligible "may receive some benefit from diagnostic and treatment services directed at treating the health and well-being of the child: (such as family therapy services) to reduce or treat the effects of the mother's condition on the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child." The bulletin indicates "such services must be covered under a 1905(a) benefit such as rehabilitative services or other licensed practitioner services."

- **CMSC Information Bulletin. July 7, 2014. Clarification of Medicaid Coverage of Services to Children with Autism and EPSDT Requirements.** This bulletin provides information that reinforces CMS rules for EPSDT benefit requirements. It stipulates that "States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be

[32] CMCS Informational Bulletin. (2016, May 11). *Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children*. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf.
[33] Veriker, T., Macomber, J. & Golden, O. (2010, August). *Infants of depressed mothers living in poverty: Opportunities to identify and serve*. The Urban Institute. Retrieved from http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412199-Infants-of-Depressed-Mothers-Living-in-Poverty-Opportunities-to-Identify-and-Serve.PDF.

medically necessary to correct or ameliorate any physical or behavioral health conditions."[34] These categories include services of other licensed practitioners and behavioral modification such as Applied Behavioral Analysis (ABA) (both of which are covered under the Nebraska State Plan), as well as preventive and therapy services. It is important to understand the requirements of this bulletin and explore opportunities to obtain Medicaid reimbursements that can offset state costs while maintaining budget neutrality.

Finding B-4. State funds, rather than Medicaid funds, appear to be paying for Medicaid-covered services for children and youth who are Medicaid-eligible. One of the best approaches to braiding funds is to utilize Medicaid funding for all covered services provided to Medicaid-eligible youth. This allows the state to reserve state general funds and other resources for those who are not eligible for Medicaid or for services that are not covered by Medicaid. While recognizing that not all children are eligible for Medicaid, it appears from available information that not all Medicaid-covered services for enrolled youth are paid for by Medicaid. Typically, across states, the reasons for this situation vary:

- Medicaid regulations and operational guidance may not be sufficiently detailed to include the full array of coding and services authorized under the State Plan, including EBPs and services provided by licensed practitioner.
- The medical necessity for the service is not established.
- State Entities that are responsible for the safety and security of children/youth, and have the responsibility to protect the community, need easy access to services. The entities may pay for Medicaid-covered services with state dollars to quickly obtain placement or services that may not be medically necessary for psychiatric reasons, but are needed for either the safety of the child/youth or the community.
- It is often easier for a provider to bill non-Medicaid entities than develop the capacity to bill Medicaid or apply to be part of a BHO/MCO to obtain payment. Obtaining payment through an annualized contract for services funded through state dollars is easier for providers and also offers a steady stream of income rather than billing on an encounter basis. In order to leverage state dollars to the maximum benefit and obtain Medicaid reimbursement, it is highly desirable for all providers (involved with the state entitles) that offer covered Medicaid services to be defined as essential providers and included in the BHO/MCO provider networks (if these providers meet credentialing standards).

Finding B-5. PRTF utilization as reported by the State Entities is higher than desired and there is disproportionate use of PRTFs by minorities in Nebraska, based on the percentage of

[34] CMCS Informational Bulletin. (2014, July 7). *Clarification of Medicaid coverage of services to children with autism*.

minorities using PRTFs in comparison to the proportion of minorities within the state.[35] **Disproportionate use by minorities is consistent with PRTF utilization nationally.** While PRTFs are a necessary inpatient level of care for youth who pose a severe and imminent risk to themselves or others, many youth with behavioral challenges such as fire setting, sexual acting out, potential suicidality, or potential harmful behavior to others can be handled in other settings. Nationally, PRTFs are often used by states and the judicial system when a child or youth has not had access to appropriate services. More often than not, the literature indicates that PRTF admissions occur when there is simply no place for the child or youth to live. They may also be used to punish a child or youth as a "lock-up," despite the best intentions of program administrators. An early study of children in PRTFs found that more than a third were inappropriately placed.[36] In Nebraska, the State Entities have worked very hard to use PRTFs for the provision of treatment and supervision and not use such services as a punishment.

While Nebraska has a current protocol in place for assessing the need for PRTFs when Medicaid is the payer, nationally the experience suggests that PRTFs are used for various reasons that may not have anything to do with clinical needs. The literature indicates there are gaps in conducting assessments for the different types of risks experienced by youth such as suicidality or harm of others due to mental illness, which is different from criminogenic risk factors, sexual acting out, challenges related to alcohol and drug use, and child/youth safety/protective needs. When these different risk factors are not jointly and uniformly assessed, youth may get referred to PRTFs for reasons that may not match the treatment program of the facility. The literature is clear on the overall ineffectiveness of PRTFs. At best, results are mixed in addressing the reasons for admission.[37]

Another challenge associated with PRTF use is the length of stay. For example, when there is a determination of medical necessity for a specified length of treatment and the youth is ready for discharge (and the care is no longer medically necessary), the lack of an alternative place for the youth to live may result in Nebraska using general funds to continue supporting the youth in the PRTF. The research literature points to the ineffectiveness of care under these circumstances and the potential harm to youth when they stay in these settings. For example, in a review of the literature, The Bazelon Center for Mental Health Law found there is little evidence that PRTF admission has any positive impact at all on children's mental health.[38] Several studies suggest that any progress occurring during PRTF treatment does not necessarily

[35] Additional data can be found at the individual entity analysis sections of this report.
[36] Lyons, J.S., Libman-Mintzer, L.N, Kiseil, C.L., & Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential treatment. *Professional Psychology, Research and Practice*, *29*(6), 582-587.
[37] Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: A statewide evaluation. *Journal of Child and Family Studies*, *10*, 333–345.
[38] Judge David L. Brazelon Center for Mental Health. (n.d.). *Fact sheet: Children in residential treatment centers*. Author. Retrieved from http://www.bazelon.org/LinkClick.aspx?fileticket=D5NL7igV_CA%3D&tabid=247.

transfer back to the youth's home environment. This can result in repeated reliance and referrals back to PRTFs because the youth has not learned how to live in the community. These programs do not typically work well because they are not matched well to the youth's needs (often due to the need for "a place to live"), the practices delivered are not evidence-based, there is a lack of family involvement due to the facility's distance from youths' home communities,[39] and the environment of mixing youth with behavioral problems promotes learning additional dysfunctional behavior.[40]

Our discussions with key informants and analysis of data from the State Entities revealed that residential treatment facilities have multiple payers even when the child or youth is eligible for Medicaid. Based on these discussions, our analysis, and our overall experience, several factors contribute to this issue, for example:

- While judges provide court orders they believe are in the best interest of the youth and the community, the time pressures for finding a place for the youth to live may result in an order to residential treatment without adequate assessment and authorization of Medicaid services. State Entities may respond to the judicial order by paying for the care, even when provision of an alternative service (if available) would better meet the youth's needs.
- Limited knowledge about community alternatives to residential treatment facilities and actual service gaps may result in reliance on these programs over other community services.
- There is a tendency to equate restrictiveness of services with service intensity. Access to a locked facility with the availability of psychiatric treatment may seem to be the best alternative, when in fact the outcomes for youth placed inappropriately in residential treatment facility services are poor.
- Limited access to and brief lengths of stay for inpatient care tend to lead to the perception that residential treatment facilities can provide stabilization, which often then leads to a longer residential treatment facility length of stay due to limited community-based options.
- Some youth involved in the child welfare system or with other state agencies are placed in residential treatment facilities for long periods of time due to perceptions that their needs cannot be met in less restrictive, alternative treatment settings.
- There is limited availability of crisis and diversion services such as crisis respite or crisis residential services.

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[39] Friesen, B. J., Kruzich, J. M., Robinson, A., Jivanjee, P., Pullmann, M., & Bowles, C. (2001, Spring). Straining the ties that bind: Limits on parent-child contact in out-of-home care. *Focal Point*, 15(1). Retrieved from https://www.pathwaysrtc.pdx.edu/pdf/fpS0110.pdf.

[40] Dishion T. J., McCord J., & Poulin F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist*, *54*, 755 – 764.

The use of PRTFs results in children/youth being placed far from their home communities and families, which is challenging for families and makes it difficult to provide family therapy or reintegrate the youth back into their communities, often resulting in multiple PRTF admissions. The Surgeon General also cited research indicating that placement with other peers who are troubled is a major risk factor for later behavioral problems.[41]

PRTFs have an important role in the NeSOC for children who need this level of care, yet the focus should be on intensive treatment as well as restrictiveness, and the level of intensity of the treatment and security should match the child's/youth's needs and risks. The availability of treatment group homes within Nebraska is a critical service that already complements the use of PRTFs, but other residential and family-based options need to be available and each model must target and address specific needs.

Recommendations for Changing Utilization Patterns and Leveraging Funding

Recommendation B-1. State general funds should be targeted primarily for matching Medicaid BH services, paying for non-Medicaid covered services, and paying for BH services when individuals are not eligible for Medicaid. Some states have also used state dollars as a means of building service capacity, financing start up for new services, and training providers on new EBPs. Once the services are established, Medicaid may be able to reimburse for the EBPs if the service is included in the State Plan or other Medicaid authorities. However, State funds should not be used to pay for Medicaid-covered services for the convenience of providers. Small providers, substance use treatment providers, and family/youth peer support / family navigation services operated by peers/families may need time to develop the administrative expertise to bill Medicaid through technical assistance provided by the State, managed care vendors, and private foundations. An option that some states use to assist providers with joining Medicaid networks is to define current providers in good standing as "essential providers." This allows them to be included in the MCO/BHO provider networks as long as these providers meet credentialing criteria and can produce the minimum documentation required for Medicaid audits. Often, the State Entity holding the provider contract or the MCO/BHO provides technical assistance to develop the provider's capacity for compliance with Medicaid requirements to bill for covered services.

Recommendation B-2. Establish a workgroup co-facilitated by DBH and the Division of Medicaid and Long Term Care, with participation from clinical and financial representatives from each of the State Entities, to review finding B-2 in this document (related to Nebraska's current Medicaid benefits for children and youth ages 0 to 20 years) and determine if the EBP

[41] Rivera, V.R. & Kutash, K. (1994). *Components of a System of Care. What does the Research Say?* (As cited in Mental Health: A report of the Surgeon General, 1999).

and PP priorities and other effective services identified by the NeSOC a) are fully covered through the current Nebraska State Plan and waiver authorities, or require amendments to the financial sections of the State Plan; b) reinsert previous language in the State Plan that added authority for covering EBPs for children; c) have billing codes and modifiers established (to pay and track the utilization of these services); and d) include costs for training, certification (if required), and fidelity assessment in the provider rates. DBH, as the lead clinical organization for NeSOC, should continue to have input into the determination of the service definition and staffing requirements for behavioral health services, with input from DPH for opioid management and from DCFS, DDD, and AOP JS on the specific service needs of their populations. The Division of Medicaid and Long Term Care should have the authority to determine reimbursement, coding, payment methodology, provider qualifications, and services definitions, consistent with CMS financing and program requirements. These roles need to be articulated to assure that the clinical integrity of the services meet national standards and the program integrity and programmatic and financing/costs meet CMS requirements, including budget neutrality and the state of Nebraska's budget and regulatory requirements for Medicaid reimbursement.

The workgroup should review the Medicaid State Plan and waiver benefits and options and address the coverage of specific benefits described in the NeSOC grant application and broader SOC goals. The workgroup should also address coverage options identified in findings B-3 and B-4 described in this section for wraparound planning/care coordination, **early intervention services for first episode psychosis, maternal depression screening and treatment under EPSDT**, and EPSDT options identified in the autism informational bulletin guidance and other recent CMS guidance.

Recommendation B-3. Assess the need to enhance the Medicaid enrollment process for eligible families. AOP JS indicated that the Medicaid enrollment process works very well for their children/youth and is a model of cooperation. It will be important to assess if the same approach exists across the DHHS Divisions. As the NeSOC moves forward and the locus of wraparound services is further implemented by RBHAs, it will be important for the NeSOC wraparound/care coordinators to have linkages to assist youth and family with Medicaid enrollment when they are eligible.

Recommendation B-4. Implement a targeted psychiatric residential treatment facility (PRTF) utilization reduction program that includes transitioning children and youth who are inappropriately placed in PRTFs to family- and community-based services, and developing a range of residential options, including specialized PRTFs. Strategies for this approach include:

- Identify all youth in PRTFs regardless of funding source, across all State Entities.
- Assign wraparound care coordination teams to work with children/youth in PRTFs to conduct ongoing reviews and assist with community reintegration and discharge

planning. This is especially important for youth placed in PRTFs for longer lengths of time as well as those who have had multiple PRTF admissions and/or do not appear to be achieving treatment goals. This may be accomplished through Medicaid administrative case management without a State Plan amendment. Note: while a child is in a PRTF, Medicaid services under HCBS and targeted case management are not billable if the facility is an institution for mental disease (IMD).

- Review the current PRTF assessment process to determine if it measures mental health risks, criminogenic risk, unsafe behaviors, and child/youth safety factors. (We recommend that standardized tools used in the assessment process address all of these risk factors for the NeSOC target population, for any level of care, in order to mitigate concerns about the appropriateness of services.) Update the assessment process and relevant tool(s) as needed to address these multiple factors. Incorporating criminogenic risk factors into the assessment process is important to avoid co-mingling youth with and without these factors as well as to ensure that when youth have criminogenic risks, the treatment approach addresses these risks.
- Selection of an appropriate tool should be discussed in the context of training needs, current tools in use, and the effectiveness of the tools. Nebraska's Region 3 uses the Child Adolescent Needs Assessment (CANS) developed by John Lyons, and the State Entities have had some discussion about broadening its use outside Region 3. TriWest understands that BHO-contracted providers have access to the CANS. Online CANS training is available and residential providers utilize the CANS in treatment planning efforts. The CANS is the most widely used assessment tool for SOC known to TriWest Group.[42] States that are using the CANS or intend to use it include Louisiana, Maryland (CANS and CASII), Massachusetts, New Jersey, New York, Ohio, West Virginia, Texas, and Dane County and Milwaukee in Wisconsin. Dr. Lyons usually develops an algorithm specific to the state's needs that can include a variety of risk factors. Other states, including Michigan, use the Child and Adolescent Functional Assessment Scale (CAFAS). Cuyahoga County, Ohio uses the Ohio Scale, as does Oklahoma; Georgia uses various tools.[43]
- Once the assessment tool is identified and staff are trained on its use, conduct assessments of the Medicaid-eligible PRTF residents who did not meet medical necessity and as a result are funded by DBH, DCFS, or AOP JS. We recommend starting with this population to determine if the youth requires PRTF and if medical necessity can be established in order to bill Medicaid for their services rather than using state general funds. If medical necessity is not established, then other levels of care should be considered.

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[42] For information about the CANS, please see: http://www.chapinhall.org/experts/john-lyons.

[43]Simons, D., Pires, S. A, Hendricks T., & Lipper, J. (2014 July). *Intensive care coordination using high quality wraparound for children with serious behavioral health needs. State and community profiles*. Center for Health Care Strategies, Centers for Medicare & Medicaid Services.

- For youth who do not meet PRTF medical necessity criteria, first assess if intensive home-based alternatives would meet their needs, especially with additional wraparound planning resources. Consider if other EBPs and PPs that are not currently available, such as HOMEBUILDERS®, would be useful for the current population of youth in PRTFs. For example, HOMEBUILDERS® provides intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care.[44]
- Depending on the individualized needs of the current PRTF population, the services that would best fit their needs may not currently exist. It may be useful to issue a Request for Information (RFI) or Request for Proposals (RFPs) to serve youth currently residing inappropriately in PRTFs to obtain EBPs that match their needs. The RFI/RFP process may help assess if current providers could offer alternative services.
- For youth who do not meet PRTF medical necessity criteria, but still may need a residential option due to their specific needs, it is important to develop a subset of residential options for youth who require immediate access to a safe and secure living situation. These resources should be limited in number, but are necessary to avoid homelessness and over-reliance on crisis systems (including hospital emergency departments), psychiatric facilities, or detention. We recommend that the NeSOC focus its planning effort on the types of service alternatives that most effectively address the needs of individual children/youth. In addition to current Nebraska modalities of therapeutic group homes, crisis stabilization, and Professional Resource Family Care / treatment foster care, the range of options we have recommended in other states has included the residential models listed below:
  - Extended sub-acute stabilization or acute residential services that serve as an inpatient alternative for providing stabilization and treatment while the Wraparound team works on transition planning back to the family or other more natural settings. The length of stay is generally less than 30 days.
  - Medium-term family-oriented residential services, a specialized model that is often referred to as family-based residential, that would meet the needs of the youth and community safety while also working intensively with families and providing treatment to the youth. The length of stay is 30 to 60 days.
  - Longer-term (three to 12 months) intensive and restrictive PRTFs will continue to be necessary for some youth with ongoing complex or dangerous behaviors. The model should focus on providing intensive (as distinct from only restrictive) treatment services.

It would be useful to work with existing PRTF providers to transition current services to the program models and crisis services listed above, assuming these do not already exist in

[44] For more information on HOMEBUILDERS, please see: http://www.institutefamily.org/programs_IFPS.asp.

Nebraska. We want to reiterate that this is not an expansion of the Medicaid program, but rather a modification of the residential service array and crisis system to meet the individualized needs of children and families.

Recommendation B-5. Screen all children/youth in the NeSOC for Title IV-E eligibility. The Federal Foster Care Program, authorized by title IV-E of the Social Security Act as amended and implemented under the Code of Federal Regulations (CFR) at 45 CFR parts 1355, 1356, and 1357,[45] helps to provide safe and stable out-of-home care for children until they are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements for permanency. Because this is an entitlement program and funding is not capped, Title IV-E eligibility for children should be pursued for any child entering the NeSOC. Funds are available for monthly maintenance payments for the daily care and supervision of eligible children; administrative costs to manage the program; training of staff and foster care providers; recruitment of foster parents; and costs related to the design, implementation, and operation of a state-wide data collection system.

Recommendations for Medicaid Health Plans and Commercial Insurers

Recommendation B-6. Implement universal screening, assessment and treatment for behavioral health (BH) conditions for individuals with positive screens within Medicaid health plans. Collaborate with Medicaid plans and commercial insurers to encourage implementation of universal screening, assessment, and treatment for BH conditions, consistent with Nebraska and federal parity laws. As described earlier in this report, early identification, screening, and treatment for mental health and substance use conditions have better outcomes and promote efficiencies. The impact on children of parents with untreated BH conditions is likely to predispose the children to BH challenges as they age. Examples of tools that could be universally implemented are the Screening Brief Intervention and Referral to Treatment (SBIRT)[46] for substance use and the PHQ-9[47] for depression. We encourage the use of collaborative care models for the treatment of depression and other BH conditions within primary care practices, which have demonstrated good outcomes and cost savings.[48, 49] By collaborative care, we mean "a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. In addition to case management support, primary care providers receive consultation and

[45] See http://www.acf.hhs.gov/programs/cb/resource/title-ive-foster-care.
[46] See http://www.samhsa.gov/sbirt.
[47] See http://cqaimh.org/pdf/tool_phq9.pdf.
[48] Washington State Institute for Public Policy. (2014, May). *Collaborative primary care for depression with comorbid medical conditions. Benefit-cost estimates updated December 2014. Literature review updated May 2014.* Washington State Institute for Public Policy Benefit-Cost Results.
[49] Grochtdrels, T., Brettschneider, C., Weggener, A. et al. (2015). Cost-effectiveness of collaborative care for the treatment of depressive disorders in primary care: A systematic review. *PLoS ONE 10*(5): e0123078. doi:10.1371/journal.pone.0123078.

decision support from mental health specialists (i.e., psychiatrists and psychologists). This collaboration is designed to (1) improve routine screening and diagnosis of depressive disorders; (2) increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders; and (3) improve clinical and community support for active client/patient engagement in treatment goal-setting and self-management."[50] Implementation of these early intervention and prevention strategies are likely to have a positive outcome on service utilization and cost over two generations.

Recommendations for Foundations and Private Contributions

Recommendation B-7: Engage assistance from foundations and private contributions. There are several important areas where foundations and private contributions can be very helpful:

- Funds for training and fidelity monitoring of EBPs and PPs is a critical area that is often overlooked by government funding initiatives. While it is possible to include training, certification, and quality management activities in Medicaid and state general fund rates, another option is to fund a center of excellence or public university to provide ongoing training and fidelity monitoring within Nebraska. Medicaid administrative funding is available for the Medicaid portion of those costs, but foundations and private contributions could fund costs associated with non-Medicaid eligibles and services.
- Start-up costs for new programs is another area that foundations have been willing to support in Nebraska. Resources to hire staff, obtain space, provide training, and implement new programs are critical because government rates do not typically include these costs. The private sector can be very helpful to new initiatives by sponsoring pilot projects and testing new approaches until Medicaid or other reimbursements are available.
- Covering capital costs for equipment used in telepsychiatry or two-way mirrors for implementation of PCIT, for instance, are good examples of how foundations and private contributors can help. Capital costs for supportive housing are also critical, especially for emerging adults leaving foster care or residential treatment who need permanent, stable housing.
- Contributions for supported employment and supported educational services for youth, including provision of job sites, scholarships, and academic endowments, make it possible for youth to reach their employment and education goals. These services can also be funded for Medicaid-eligible youth out of HCBS and waiver authorities.
- An emerging public-private financing option is the use of social impact bonds (SIBs), a type of pay-for-success bond or social innovation financing. This model includes collaboration among public, private, and nonprofit sectors to achieve cost savings and

[50] Thota, A. B., Sipe, T.A., Byard, G.J. et al. (2012). Collaborative care to improve the management of depressive disorders: A community guide systematic review and meta-analysis. *American Journal of Preventive Medicine, 42*(5): p. 525.

improve social outcomes in areas such as criminal justice, juvenile justice, education, foster care, and homelessness.[51] A private investor fronts funds via a "bond" to a non-profit organization and assumes risk for the program. If the government's cost savings is equivalent to the bond amount, the government will reimburse the private investor. If this option is of interest to the entities, further review of the outcomes of current SIBs should be explored.

Cross-System Analysis

Summary

Thirty-two percent of spending on behavioral health services for children and youth across all the child/youth-serving entities is for out-of-home placements or restrictive levels of care.[52] Sixty-eight percent of BH spending is spent on other services, including some home- and community-based services. Based on these spending levels, there is opportunity to substitute in-home and family-based interventions for the current use of out-of-home and restrictive placements. The need for some level of out-of-home placements and restrictive levels of care will likely always be necessary. But, given these figures, there should be an effort to cover in-home and family-based alternatives and to work with residential providers to offer alternative services. Furthermore, Medicaid dollars account for over half of all spending on BH services for children in all the State Entities combined. There appears to be opportunity to leverage state general funds to obtain additional Medicaid dollars without increasing the cost to the state by reducing use of high-cost services and revising the State Plan to fund evidence-based practices (EPBs) and promising practices (PPs). To summarize:

- Total spending on BH services by all the NeSOC partners is $82,129,933.
- Total spending on children in out-of-home placements is $8,500,956, or 10% of total spending on BH services.
- Total spending on children served in restrictive levels of care is $17,531,672, or 21% percent of total spending on BH services.
- When combining spending on out-of-home care and restrictive levels of care, total spending for children in these settings is $26,032,628, or 32% of total spending on BH services.

Additional information in this section discusses the prevalence of mental health conditions and

[51] Tran, M. (2014, February 18). *Social impact bonds gain momentum in the criminal justice field*. Council of State Governments Justice Center. Retrieved from https://csgjusticecenter.org/reentry/posts/social-impact-bonds-gain-momentum-in-the-criminal-justice-field/.

[52] TriWest uses the term "out-of-home placements" recognizing that some of the placements are treatment focused and others are substitute living situations for the biological family home. It is important to distinguish between treatment programs and other interventions that offer shelter and care.

the Pires Prevalence Pyramid,[53] which indicates that about two to five percent (2-5%) of children use the highest levels of care and the most resources. This population matches the SED target population of the NeSOC. We also found that minority youth are using more out-of-home placements and restrictive levels of care. The need to shape culturally relevant services and supports while implementing in-home and family-based care is essential (this point was also made by the NeSOC planning groups in various documents).

Population and Characteristics

Nebraska has a total population of about 1.8 million residents.

Table 3. Nebraska Census by Regions: 2013 Population Estimates (State Total = 1.8M) [54]

Regions	Region Office	Counties	Population	% of Population
R1 Panhandle/Western	Scottsbluff	11	87,104	4.7%
R2 South Western	North Platte	17	100,642	5.4%
R3 South Central	Kearney	22	229,646	12.3%
R4 Northeast & North Central	Norfolk	22	206,304	11%
R5 Southeast	Lincoln	16	456,138	24.4%
R6 Eastern	Omaha	5	788,682	42.2%

According to the Kaiser Family Commission, in 2014, 25% of Nebraskans were children between the ages of zero and 18 years, and 9% were between the ages of 19 and 25 years. The poverty rate of children ages zero and 18 years was 19%, compared to the US average of 21%. Ninety-five percent of Nebraskans were citizens, with 99% of children being citizens.[55]

Prevalence of Children/Youth MH Needs in a 12-Month Period

From earlier work TriWest completed on the prevalence of mental health conditions in children and youth, we have adapted figures from national and regional epidemiological studies to the population of children and youth in Nebraska. The table below provides an overview of the overall prevalence for four different age groups: young children (ages 0-5), children (ages 6-11), youth (ages 12-17), and young adults (ages 18-21).

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[53] S. Pires. Et al. (2014). Human Services Collaborative. Washington, D.C. http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2014/Resources/Seminar%206_Building%20SOC%20Using%20a%20Primer_ppt%20slides.pdf.

[54] Nebraska Department of Health and Human Services. (2016, May). *SOC Expansion and Sustainability FOA No. SM-16-009. (*Unpublished federal grant application provided by DHHS), p. 6.

[55]Kaiser Family Foundation. (n.d.) State health facts. Author. Data is for 2011. Accessed June 1, 2016 at http://kff.org/state-category/demographics-and-the-economy/.

Table 4. Prevalence of Nebraska Children/Youth with Mental Health Needs in a 12-Month Period

Age Group[56]	Mental Health Need	
	Number	Percentage of pop.
Ages 0-5[57] (pop. = 157,127)	34,568	22.0%
Ages 6-11 (pop. = 159,926)	35,184	22.0%
Ages 12-17[58] (pop. = 153,284)	61,773	40.3%
Ages 18-21[59] (pop. = 110,032)	46,870	42.6%
Total for Ages 0-21 (pop. = 580,039)	**178,395**	

[56] U.S. Census Bureau. (2016, June). Nebraska population by age estimates for 2015. Retrieved June 23, 2016 from http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.

[57] We are not aware of a comprehensive national epidemiological study of children's mental health needs. For ages 0-5 and 6-11, we have estimated the need based on a number of studies conducted in various parts of the country. See, for example: Costello, E.J. et al. (1996). The Great Smoky Mountains study of youth: Goals, design, methods, and the prevalence of DSM-III R disorders. *Archives of General Psychiatry, 53*(12), 1129-1136. Lee Institute (2008, April). *An assessment of infant mental health needs in Mecklenberg County: A report to Smart Start of Mecklenberg County on behalf of the Infant Mental Health Working Group*. Unpublished. Retrieved from http://www.dukemansion.com/leeinstitute/pdfs/2010%20Examples%20of%20Our%20Work/IMH%20Needs%20Assessment%20Final%20Report%20to%20Printer%202.pdf. We also drew on estimates from psychiatric epidemiologist, Dr. Charles Holzer (http://www.charlesholzer.com). The estimates for children do not include substance use disorders, which are much lower in ages (0-11 years) than in the adolescent and young adult age groups.

[58] Based on the National Comorbidity Survey Replication – Adolescent Supplement (NCSRA). See Kessler, R.C. et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372-380. Note that the 40.3% figure includes the 8.3% of all adolescents in the sample who had one or more substance use disorders. However, SUDs often are comorbid with mental health disorders and, based on Merikangas et al. (2010), we estimate that 37.5% of adolescents ages 12-17 years have a mental health condition. See Merikangas, K.R. et al. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the NCSR-A. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(10), 980-989.

[59] Data on people ages 18-21 years are estimated based on extrapolations from the NCSR-A (see footnote above), the most recent and best national epidemiological studies of mental health conditions in adults, collectively known as the Collective Psychiatric Epidemiological Surveys (or CPES), as well as from the National Survey on Drug Use and Health. Kessler, R.C., et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-603. Alegria, M., et al. (2004). Considering context, space and culture: The National Latino and Asian American Study. *International Journal of Methods in Psychiatric Research, 13*(2), 208-220. Jackson, J.S. et al. (2004). The National Survey of American Life: A study of racial, ethnic and cultural influences on mental disorders and mental health. *International Journal of Methods in Psychiatric Research, 13*(4), 196-207. When we remove young adults with substance use disorders only, the estimated percentage with a mental health condition over any given 12-month period is 35%. The percentage of young adults with SUDs *only* was estimated through personal communication with psychiatric epidemiologist, Dr. Charles Holzer, on April 26, 2012. Dr. Holzer has compiled data and estimates from the CPES and other sources. See for example Lenzenweger, M.F., Lane, M.C., Loranger, A.W., & Kessler, R.C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 62*(6), 553-564.

Prevalence of Youth/Young Adult Substance Use Needs in a 12-Month Period

Next, we used data from the National Survey on Drug Use and Health to estimate the number of Nebraska youth and young adults with SUDs. The following table provides a summary of our findings.

Table 5. Prevalence of Nebraska Children/Youth with Substance Use Needs in a 12-Month Period

Age Group	Alcohol Abuse/Dependence		Substance Abuse/Dependence		Alcohol *or* Substance Abuse/Dependence	
	Number	% of pop[60]	Number	% of pop	Number	% of pop
12-17 Year Olds *(pop. =* 153,284*)*	**9,197**	**6.0%**	**5,058**	**3.3%**	**12,416**	**8.1%**
Gender						
Male (pop. = 78,258)	6,260	8.0%	3,365	4.3%	8,530	10.9%
Female (pop. = 75,026)	2,926	3.9%	1,651	2.2%	3,976	5.3%
18-21 Year Olds *(pop. = 110,032)*	**16,285**	**14.8%**	**9,243**	**8.4%**	**21,016**	**19.1%**
Gender						
Male (pop. = 56,236)	11,191	19.9%	5,961	10.6%	14,396	25.6%
Female (pop. = 53,796)	5,272	9.8%	3,282	6.1%	6,778	12.6%
Total for Ages 12-24	**25,482**	**11.8%**	**14,301**	**6.6%**	**33,432**	**15.4%**

Prevalence Compared to Utilization

It is challenging to determine the prevalence of BH needs compared to the utilization of BH services because the State Entities do not currently have the capacity to maintain unduplicated counts of the children and youth they serve. Reasons for the lack of this capacity include the need for entities to protect client confidentiality, information systems differ between entities, and contracting methods that do not match encounters by individual clients.

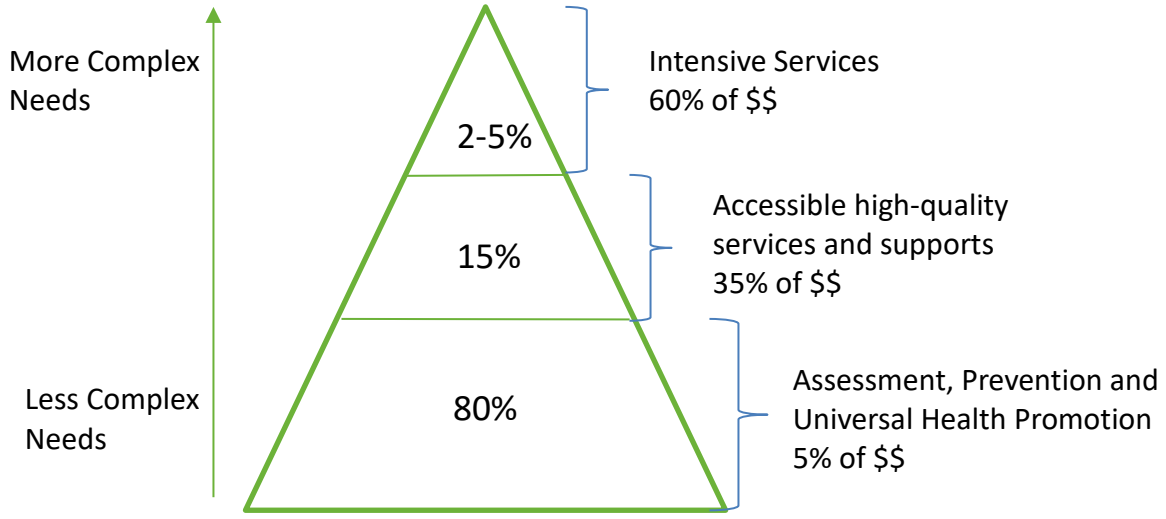
Pires Prevalence Triangle

In looking at national prevalence issues related to children and designs of systems of care,

[60] Percentages are based on the number of people within each population group estimated to have a SUD, relative to the number of Nebraska residents falling into the population group.

Sheila Pires discusses the "prevalence triangle," where, in a typical state, two to five percent of the child population with SED require intensive services and utilize 60% of funding; about 15% of the children require a range of high quality accessible services and supports and use about 35% of funding; and the remaining 80% of the population need assessment, prevention, and universal health promotion, utilizing 5% of funding.[61] The bottom of the triangle represents less complex needs and the top more complex needs, though children do move into different sections of the triangle at different periods of time. The top two to five percent of children fit the NeSOC target population: children with behavioral health challenges who are at risk of out-of-home placement, who are involved in multiple child-serving systems and/or are of transition age (16 to 21 years) and not already involved in a transition-age program. For planning purposes, if the prevalence of mental health needs ranges from 22-42.6% of the children's population, or 178,395 of the children in Nebraska (ages 0-21 years), then about two to five percent (3,568 to 8,920 children) of this population would benefit from the NeSOC. These estimates of need are in sharp contrast to the number of Nebraska children and youth currently receiving intensive, team-based services, such as MST and Wraparound. For example, later in this section of the report, we show that only 85 children and youth involved with AOP JS received MST services in fiscal year 2015, and that DBH spent less than $100,000 in that same year on MST and Professional Partner School Wraparound services.

Figure 2. Pires Prevalence Triangle



[61] S. Pires et al. (2014). Human Services Collaborative. Washington, D.C. http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2014/Resources/Seminar%206_Building%20SOC%20Using%20a%20Primer_ppt%20slides.pdf.

Current Spending and Utilization Patterns Across State Entities and Services

Total Spending on BH Services or on Services for Children with BH Challenges by State Entities

Table 6, below, includes the information provided by the State Entities regarding spending on BH services or services for children with BH challenges, including the number of children served and the cost per child in state fiscal years (SFY) 2014 or 2015. At the time of this report, an unduplicated count of children served was not available. DBH reported a total of 5,471 children and youth were served. This represents about 2,400 individuals that received community-based services, based on estimates.[62]

Table 6. Total Spending on BH Services by State Entity and Children Served

State Entity	Total Spending	Number of Children Served[63]	Cost per Child Served
DBH	$10,099,329	5,471	$1,846
DCFS	$6,266,814	442	$14,850
DDD[64]	N/A	241	N/A
DPH[65]	N/A	N/A	N/A
Medicaid[66]	$49,924,301	15,940	$3,132
AOP JS	$15,839,489	5,708	$2,775
Totals	**$82,129,933**	**27,802**	**N/A**

Total spending on BH services by all the NeSOC partners is $82,129,933. **Medicaid dollars account for just over half of all spending on BH services for children in all the State Entities combined.**

[62] Separate data collection efforts resulted in these estimates. The 5,471 figure was provided by DBH to TriWest via data request (2016, Jan). The annual figure for children that received community-based services was separately reported as part of the NeSOC planning effort. Nebraska Department of Health and Human Services. (2016, May). *SOC Expansion and Sustainability FOA No. SM-16-009. (*Unpublished federal grant application provided by DHHS), p.8.

[63] The total number of children served reflects duplication due to the challenges of tracking utilization across state entities.

[64] Specific expenditure data for BH services provided by DDD was unavailable at the time of this report.

[65] The data provided only focused on a portion of all expenditures and services provided by DPH. Total spending on BH and children served was unavailable at the time of this report.

[66] Total spending figure includes FFS only expenditures for SFY14; an additional $45,770,864 was expended in capitation payments between September 2013-June 2014 for an average of 155,478 monthly enrollees. SFY14 BH expenditures totaled $95,695,165.

Table 7. Total Amount Spent and Number of Children Served in Out-of-Home Placements (exclusive of hospitals and residential treatment centers)

State Entity	Total Spending on Out-of-Home Placements	Number of Children Served	Average Cost per Child Served
DBH[67]	N/A	122	N/A
DCFS[68]	$845,550	24	$35,231
Medicaid[69]	$3,172,676	197	$16,105
AOP JS[70]	$4,482,730	152	$29,492
Totals	**$8,500,956**[71]	**495**[72]	**$22,791**[73]

Total spending on children in out-of-home placements is $8,500,956 or ten percent of total spending on BH services.

Use of Restrictive Levels of Care

Table 8. Total Amount Spent and Number of Children Served in Restrictive Levels of Care

State Entity	Total Spending on Restrictive Levels of Care	Number of Children Served	Average Cost per Child Served
DBH[74]	N/A	1,019	N/A
DCFS[75]	$5,015,107	78	$64,296
Medicaid[76]	$1,903,909	445	$4,278
Probation[77]	$10,612,656	306	$34,682

[67] Includes therapeutic communities, dual diagnosis residential, half-way house, psychiatric residential rehabilitation, short-term residential.
[68] Includes therapeutic group homes (ThGH) and structured, out-of-home care.
[69] Includes therapeutic group home and other 24 hour residential services.
[70] Includes JSH Therapeutic Group Home, MH Therapeutic Group Home, SUD Short Term Residential, and SUD Therapeutic Group Home expenses covered by AOP Juvenile Services.
[71] Total spending does not include DBH expenditures, which were unavailable at the time of this report.
[72] The total number of children served represents an estimation due to duplication in services across state entities.
[73] The average cost per child served is an estimate, and does not include DBH expenditures, which were unavailable at the time of this report.
[74] Includes acute psychiatric inpatient, intensive residential, secure residential, civil protective custody, emergency protective custody, sub-acute.
[75] Includes PRTF (hospital-based, specialized, and non-specialized) and inpatient.
[76] Includes PRTF and inpatient, FY 2014.
[77] Includes acute inpatient hospitalization, specialized and hospital PRTF expenses covered by AOP Juvenile Services.

State Entity	Total Spending on Restrictive Levels of Care	Number of Children Served	Average Cost per Child Served
Totals	**$17,531,672**[78]	**1,848**[79]	**$21,148**[80]

Total spending on children served in restrictive levels of care is $17,531,672 or 21 percent of total spending on BH services. Tables 7 and 8 provide an estimate of the number of children in either out-of-home care or very restrictive care; these children are the target population for the NeSOC. While Medicaid data on the number of children in out-of-home placements or in restrictive levels of care was unavailable at the time of this report, 12 percent of their budget is spent on these services. DBH expenditure data for these services was also unavailable, but the children who were served by DBH in restrictive or out-of-home placements respectively comprised 73 percent and 41 percent of all children served in these settings across the State Entities.

[78] Total spending does not include DBH expenditures, which were unavailable at the time of this report.
[79] The total number of children served represents an estimation due to duplication in services across state entities.
[80] The average cost per child served is an estimate, and does not include DBH expenditures, which were unavailable at the time of this report.

State Entity Comparison: Behavioral Health Spending and Utilization by Type of Service

Table 9. Behavioral Health Spending and Utilization by Type of Service for AOP JS, Medicaid, and DCFS[81]

Service Type	AOP JS, SFY15			Medicaid, SFY14[82]			DCFS, SFY15		
	Expenses	Youth Served	Cost per Child	Expenses	Youth Served	Cost per Child	Expenses	Youth Served	Cost per Child
Psychiatric Residential Treatment Facility (PRTF)	$9,434,106	261	$36,146	$625,524	33	$18,955	$4,144,040[83]	65	$63,754
Specialized PRTF	$1,178,550	45	$26,190	N/A	N/A	N/A	$739,792	12	$61,649
Therapeutic Group Home	$2,174,704	56	$38,834	$301,537	42	$7,179	$651,895	15	$43,460
Inpatient	N/A	N/A	N/A	$1,278,385	414	$3,088	$131,275	1	$131,275
Structured, Out-of-Home Care	N/A	N/A	N/A	N/A	N/A	N/A	$193,655	9	$21, 517
24 Hour Residential (Other)	N/A	N/A	N/A	$2,871,139[84]	158	$18,172	N/A	N/A	N/A
Day Treatment/Partial Hospitalization	$7,840	1	$7,840	$239,357	99	$2,418	$54,179	13	$4,168
Day Rehabilitation	N/A	N/A	N/A	$5,185	N/A	N/A	N/A	N/A	N/A
Intensive Outpatient	$216	2	$108	N/A	N/A	N/A	$72,792	35	$2,165
MH Outpatient Services	$105,560	140	$754	$7,084,651[85]	14,395	$492	$279,186[86]	292	$956
Community Support	N/A	N/A	N/A	$3,967	8	$496	N/A	N/A	N/A
Community Treatment Aides	N/A	N/A	N/A	$265,279	302	$878	N/A	N/A	N/A
Multisystemic Therapy	$229,068	54	$4,242	N/A	N/A	N/A	N/A	N/A	N/A

[81] The total number of youth served reflects duplication due to the challenges of tracking utilization per child across state entities.
[82] Medicaid data for SFY15 was unavailable at the time of this report.
[83] This figure also includes expenditures for hospital-based PRTF.
[84] This figure includes expenditures for residential rehabilitation and other residential treatment services.
[85] Service expenditures include BH assessment and therapy.
[86] Service expenditures include individual, family and group psychotherapy.

Service Type	AOP JS, SFY15			Medicaid, SFY14[82]			DCFS, SFY15		
	Expenses	Youth Served	Cost per Child	Expenses	Youth Served	Cost per Child	Expenses	Youth Served	Cost per Child
SUD Services	$2,100,330[87]	440	$4,773	$12,869[88]	17	$757	N/A	N/A	N/A
JSH Services	$609,115[89]	24	$25,380	N/A	N/A	N/A	N/A	N/A	N/A
Injections	N/A	N/A	N/A	$5,196	88	$59	N/A	N/A	N/A
Electroconvulsive Therapy (ECT)	N/A	N/A	N/A	$987	2	$439	N/A	N/A	N/A
BH Medications	N/A	N/A	N/A	$37,052,634	20,482	$1,809	N/A	N/A	N/A
BH Transportation	N/A	N/A	N/A	$172,512	1,691	$102	N/A	N/A	N/A
Other BH Services	N/A	N/A	N/A	$5,081	85	$60	N/A	N/A	N/A
Totals	**$15,839,489**	**1,023**	**$15,483**	**$49,924,303**[90]	**15,940**[91]	**$3,132**	**$6,266,814**	**442**	**$14,850**

Table 9, above, offers a comparison of spending and utilization by common types of services delivered by AOP JS, DCFS, and Medicaid. Spending on mental health outpatient services ranged from $492 per child served by Medicaid to $956 per child served by DCFS. Day treatment or partial hospitalization ranged from $2,418 per child served by Medicaid to $7,840 per child served by AOP JS. Unduplicated counts of children served and data on spending in common service categories were not available for each State

[87] Service expenditures include intensive outpatient, intervention/education, outpatient treatment, partial care, short-term residential, therapeutic group home for SUD.
[88] Service expenditures include intensive outpatient, short-term residential, detox, group counselling, and community supports for SUD.
[89] Service expenditures include JSH intensive outpatient, JSH outpatient, and JSH therapeutic group home.
[90] Service expenditures exclude capitation payments for BH managed care enrollees incurred from 9/2013 to 6/2014, plus any retroactive adjustments or reconciliations, and the portion of Risk Corridor payment attributable to enrollees <21 years old. Grand total of expenditures, including capitation for FY 2014, was $95,695,167.
[91] The total number of children served reflects an unduplicated figure for FFS BH services, and does not include BH medications for service dates 07/2013-6/2014. The youth served by service type include duplicated services. A monthly average of 155,478 persons <21 are enrolled in BH Managed Care, with access to the full BH benefits package.

Entity. Going forward, it will be helpful for NeSOC if this information could be obtained by all State Entities. It is also challenging to

obtain unduplicated accounts across State Entities due to the various information systems available.

Racial, Ethnic and Gender Disproportionality in BH Service Utilization

Gender data was not available for all the State Entities, hence examination of gender disproportionality was not possible at the time of this report. Descriptive analysis of racial groups among children served revealed a disproportionality among some racial groups served within the juvenile justice system. Among youth served by AOP JS, 17% identify as African-American. Comparatively, less than five percent of Nebraskan residents are African-American. AOP JS is serving a higher proportion of African-American youth than any other State Entity contained within this report. This indicates that a disproportionate number of African-American youth are involved with the juvenile justice system in Nebraska. Unfortunately, minority youth are overrepresented in the juvenile justice system in most states.[92] The NeSOC planning team also confirmed that disparities exist among minority racial and ethnic groups in terms of challenges in gaining access to care and in use of out-of-home care and the most restrictive settings.

"Though many children and youth across all demographic groups do not receive needed mental health services, children within minority racial/ethnic populations are even less likely to receive care. Racial and ethnic disparities exist in the utilization of out-of-home care in Nebraska. The Nebraska Foster Care Review Office Quarterly Report (Nebraska Foster Care Review Office, 2016) showed significant disparities for American Indian, Black, and White children with American Indian and Black children being over-represented in out-of-home care and White children being under-represented based on DHHS Division of Children and Family Services data. These disparities in out-of-home care have remained relatively constant over past years… Nebraska's behavioral health managed care company reports that Nebraska children's utilization of inpatient, residential and recovery care management services from 3/15 to 3/16 indicates that Black children are overrepresented and White children are under-represented in the utilization of these more restrictive behavioral health services."[93]

[92]Armour, J., & Hammond, S. (2009). *Minority youth in the juvenile justice system. Disproportionate minority contact*. Retrieved on June 5, 2016 from http://www.ncsl.org/print/cj/minoritiesinjj.pdf.

[93] Nebraska Department of Health and Human Services. (2016, May). *SOC Expansion and Sustainability FOA No. SM-16-009. (*Unpublished federal grant application provided by DHHS), p.8.

Individual Summaries of the Administrative Office of Probation, Juvenile Services and Department of Health and Human Services Divisions

Administrative Office of Probation, Juvenile Services

The Administrative Office of Probation, Juvenile Services (AOP JS) is responsible for statewide administration of intake and detention alternatives, investigations, assessments and evaluations, case management and supervision, and services, placement, reentry and funding for juveniles. In addition to the Juvenile Detention Alternative Initiative, the Juvenile Services Division is also accountable for statewide leadership, support, and oversight as it relates to the Crossover Youth Practice Model.

AOP JS is also responsible for implementing Legislative Bill 561,[94] passed in May of 2013, which charged the Nebraska Juvenile Probation System to treat and rehabilitate court-involved youth as opposed to punishing them. While juvenile probation officers still have a primary responsibility to hold youth accountable, enforce orders of the court, and ensure public safety, the punitive aspect is diminished through this legislation. Probation officers also have a primary responsibility to facilitate youth rehabilitation. In coordination with judicial support, AOP JS is devoted to the successful futures of juveniles and their families. Families are empowered to be a part of the decision-making process, which greatly aids in the success of youth. Juveniles access necessary services, without barriers, at all stages of the court process, supported by financial resources for both treatment and non-treatment services.

Spending and Utilization

AOP JS spent a total of $15,839,489 in SFY2015 on mental health (MH) and substance use disorder (SUD) services for children and youth, including MH and SUD hospitalizations and physician and psychological services for 1,023 youth. Across all services, costs per youth served averaged $15,483.

Table 10. Spending and Utilization by Type of Service and Average Cost per Child, SFY2015 (July 1, 2014-June 30, 2015)

Service Type	Expenses Covered by Probation	Youth Served	Average Cost per Child (Covered by Probation)	Expenses Covered by Other Sources	Youth Served	Total Youth Served
Acute Inpatient Hospitalization	$0	0	$0	N/A	1	1

[94] See: http://nebraskalegislature.gov/FloorDocs/103/PDF/Final/LB561.pdf.

Service Type	Expenses Covered by Probation	Youth Served	Average Cost per Child (Covered by Probation)	Expenses Covered by Other Sources	Youth Served	Total Youth Served
Hosp. Psychiatric Residential Treatment Facility (PRTF)	$9,434,106	261	$36,146	N/A	123	384
JSH Day Treatment	$0	0	$0	N/A	1	1
JSH Intensive Outpatient	$16,320	3	$5,440	N/A	3	6
JSH Outpatient	$5,047	7	$721	N/A	11	18
JSH Therapeutic Group Home	$587,748	14	$41,982	N/A	2	16
Medication	$0	0	$0	N/A	1	1
MH Day Treatment	$7,840	1	$7,840	N/A	1	2
MH Intensive Outpatient	$216	2	$108	N/A	3	5
MH Outpatient Services	$105,560	140	$754	N/A	201	341
MH Therapeutic Group Home	$2,174,704	56	$38,834	N/A	1	57
Multisystemic Therapy	$229,068	54	$4,242	N/A	31	85
Spec. PRTF	$1,178,550	45	$26,190	N/A	7	52
SUD Intensive Outpatient	$222,457	149	$1,493	N/A	125	274
SUD Intervention/Education	$602	7	$86	N/A	4	11
SUD Outpatient Treatment	$152,478	197	$774	N/A	148	345
SUD Partial Care – Juvenile	$4,515	5	$903	N/A	4	9
SUD Short Term Residential	$1,620	1	$1,620	N/A	1	2
SUD Therapeutic Group Home	$1,718,658	81	$21,218	N/A	1	82
Totals	**$15,839,489**	**1,023**	**$15,483**	**N/A**	**669**	**1,692**

Count of Children Served in Community and Residential Settings

The table below summarizes the numbers of children served by AOP JS in community or residential settings for SFY2015.

Table 11. Count of Youth Receiving BH Services in the Community and Residential Settings, SFY2015 (July 1, 2014-June 30, 2015)

Service Type	Children Served – Community	Children Served – Residential	Total
Acute Inpatient Hospitalization	0	1	1
Hosp. PRTF	0	384	384
JSH Day Treatment	1	0	1
JSH Intensive Outpatient	6	0	6
JSH Outpatient	18	0	18
JSH Therapeutic Group Home	0	16	16
MH Day Treatment	2	0	2
MH Intensive Outpatient	5	0	5
MH Outpatient Services	341	0	341
MH Therapeutic Group Home	0	57	57
Multisystemic Therapy	85	0	85
Spec. PRTF	0	52	52
SUD Intensive Outpatient	274	0	274
SUD Intervention/Education	11	0	11
SUD Outpatient Treatment	345	0	345
SUD Partial Care – Juvenile	0	9	9
SUD Short Term Residential	0	2	2
SUD Therapeutic Group Home	0	82	82
Total	**1,088**	**603**	**1,691**[95]

Children Served by Age and Race

Demographic data provided on the youth served by AOP JS indicated the breakdown by age and race during SFY2015 as shown in the following tables. The majority of youth (45%) utilizing any service of AOP JS were between 15 and 16 years of age. This age group also utilized the

[95] One additional child received medication (total of 1,692 children served), but it was unknown whether this was in the context of a community or residential setting.

majority of the community (49%) and residential (37%) services.

Table 12. Children and Youth Served by Age, SFY2015 (July 1, 2014-June 30, 2015)

Age Group	Community Services[96]	Percent Using Community	Residential Services[97]	Percent Using Residential	Total	Percent Utilizing Any Service
0 – 10 years	2	<1%	1	<1%	3	<1%
11 – 14 years	201	18.5%	121	20.1%	322	19.0%
15 – 16 years	536	49.4%	224	37.1%	760	44.9%
17 – 18 years	349	32.1%	133	22.1%	482	28.5%
Unreported	N/A	N/A	124	20.6%	124	7.3%
Total	**1,088**		**603**		**1,691[98]**	

As can be seen in Table 13 below, there were certain racial and ethnic differences between the racial groups served by AOP JS during this time period. AOP JS served a higher proportion of African-American youth (17%) compared to the overall African-American population of five percent at the time. Probation also served a disproportionate amount of American Indian or Alaskan Native youth (3%) relative to the proportion of American Indians and Alaskan Native residents statewide (1%). In contrast, only 58% of youth who received AOP JS funded BH services were white, while the overall white non-Hispanic population in Nebraska was 86%.

Table 13. Children and youth served by race, SFY2015 (July 1, 2014-June 30, 2015)

Race	Community Services[99]	% Using Community	Residential Services[100]	% Using Residential	Total	% Utilizing Any Service	2010 State Census Data
White	569	52.3%	404	67.0%	973	57.5%	86.1%

[96] Services include JSH Day Treatment, JSH Intensive Outpatient, JSH Outpatient, MH Day Treatment, MH Intensive Outpatient, MH Outpatient Services, Multisystemic Therapy, SUD Intensive Outpatient, SUD Intervention/Education, and SUD Outpatient Treatment.

[97] Services include Acute Inpatient Hospitalization, Hosp. PRTF, JSH Therapeutic Group Home, MH Therapeutic Group Home, Spec. PRTF, SUD Partial Care-Juvenile, SUD Short-Term Residential, SUD Therapeutic Group Home.

[98] One additional child received medication (total of 1,692 children served), but it was unknown whether it was in the context of a community or residential setting.

[99] Services include JSH Day Treatment, JSH Intensive Outpatient, JSH Outpatient, MH Day Treatment, MH Intensive Outpatient, MH Outpatient Services, Multisystemic Therapy, SUD Intensive Outpatient, SUD Intervention/Education, and SUD Outpatient Treatment.

[100] Services include Acute Inpatient Hospitalization, Hosp. PRTF, JSH Therapeutic Group Home, MH Therapeutic Group Home, Spec. PRTF, SUD Partial Care-Juvenile, SUD Short-Term Residential, SUD Therapeutic Group Home.

Race	Community Services[99]	% Using Community	Residential Services[100]	% Using Residential	Total	% Utilizing Any Service	2010 State Census Data
African American	213	19.6%	77	12.8%	290	17.2%	4.5%
American Indian/Alaskan Native	28	2.6%	25	4.2%	53	3.1%	1.0%
Asian/Pacific Islander	7	.6%	5	.8%	12	0.7%	1.8%
Other	271	24.9%	92	15.3%	363	21.5%	N/A
Total	**1,088**		**603**		**1,691**[101]		

[101] One additional child received medication (total of 1,692 children served), but it was unknown whether it was in the context of a community or residential setting.

Division of Behavioral Health

The Nebraska Division of Behavioral Health (DBH) oversees six[102] behavioral health regions known as Regional Behavioral Health Authorities (RHBAs), which in turn contract with local agencies and programs to provide public community mental health (MH) and substance use disorder (SUD) inpatient, outpatient, and emergency services. The RHBAs provide varying levels of care, including general psychiatric services, intensive residential treatment services, inpatient mental health and sex offender services, and secure intermediate and transitional residential services.

DBH has received limited funding specifically for children and youth services. In early 2000 when behavioral health services were reformed in Nebraska, the influx of funding that occurred was specifically targeted for adult services only. As such, the primary sources of funding through DBH for youth services has been dedicated dollars from the Community Mental Health Services Block Grant and smaller state fund appropriations in response to specific events or needs.

Eligibility for Medicaid

The data from DBH indicates that about 27% of children and youth receiving DBH services were eligible for Medicaid. Medicaid eligibility was found to decrease as age increased. Nearly half (49%) of children and youth between the ages of zero and 12 years were eligible for Medicaid, while only eleven percent of young adults between the ages of 18 and 21 years were Medicaid-eligible.

Table 14. Medicaid Eligibility by Age

Medicaid Eligibility Status	Age Group Count (% within age group)			Total
	0-12 years	13-17 years	18-21 years	
Eligible/Receiving Payments	443 (44%)	556 (37%)	252 (9%)	1,251 (23%)
Eligible/Not Receiving Benefits	52 (5%)	51 (3%)	86 (3%)	189 (4%)
Potentially Eligible	129 (13%)	209 (14%)	671 (23%)	1,009 (18%)

[102] Region 1 counties include: Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan and Sioux. Region 2 counties include: Arthur, Chase, Dawson, Dundy, Grant, Hayes, Hitchcock, Hooker, Frontier, Gosper, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow and Thomas. Region 3 counties include: Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster and Wheeler. Region 4 counties include: Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston and Wayne. Region 5 counties include: Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer and York. Region 6 counties include: Cass, Dodge, Douglas, Sarpy and Washington.

Medicaid Eligibility Status	Age Group Count (% within age group)			Total
	0-12 years	13-17 years	18-21 years	
Ineligible	389 (38%	678 (45%)	1,954 (66%)	3,021 (55%)
Total	**1,013**	**1,494**	**2,963**	**5,470[1] (100%)**
[1]Medicaid status was left blank for one individual.				

Spending

In SFY2014, DBH spent $10 million in state general funds and community MH and substance abuse prevention and treatment block grants on children's MH (73% of costs), SUD (4%), and other services (23%). These funds can be leveraged to support Medicaid services for Medicaid-eligible children as well as reduce costs for uninsured children. Another $600,000 was available through federal mental health block grant funds. These block grant funds or any other federal funds cannot be used as Medicaid matching funds, but can be used to support uninsured children and pay for services not covered by Medicaid.

Table 15. Total Spending

Spending Category	SFY2014	Proportion of Costs
Amount spent on children's MH services	$7,394,972	73.2%
Amount spent on children's SUD services	$398,144	3.9%
Amount spent on other DBH-funded children's services	$2,306,213	22.8%
Grand total DBH-funded children's services	**$10,099,329**	

Spending by Type of Service

The DBH services provided to children with BH challenges during SFY2014 included MH-specific services such as intensive outpatient, outpatient therapy, Professional Partners, and medication management. The services provided to children with SUD issues included SUD-specific outpatient therapy, intensive outpatient, community supports, and family support and advocacy. The following table summarizes service expenses by category for SFY2014. MH-specific services comprised 73% of all expenditures for children's services during this time period.

Table 16. Spending by Type of Service, SFY2014

Service	Expenditures
Mental Health Services	
Youth Transitional Program/Transition Age PPP (Under 19)	$149,105

Service	Expenditures
Mental Health Services	
Professional Partner Program (PPP)	$3,835,577
LB603 Professional Partner	$757,434
Professional Partner School Wraparound	$23,391
Professional Partner Peer	$24,376
Outpatient Therapy (Individual/Family/Group)	$1,395,564
Youth System Coordination	$308,384
Multisystemic Therapy (Home-Based)	$65,440
Medication Management	$7,139
Therapeutic Consultation (P.L. 100-690)	$105,989
504 (P.L. 102-321)	$4,045
Prevention	$209,516
Youth Assessment	$251,900
Intensive Outpatient	$48,383
Crisis Response Teams (LB603)	$162,638
Respite Care	$46,091
Total MH Expenses	**$7,394,972**
Substance Use Disorder Services	
Outpatient Therapy (Individual/Family/Group)	$180,996
Youth System Coordination	$88,865
Intensive Outpatient	$45,218
Community Support	$22,229
Youth Assessment	$57,533
Family Support and Advocacy (Pilot)	$3,303
Total SUDA Expenses	**$398,144**
Subtotal DBH-Funded Children's Services through Regions	**$7,793,116**
Other Services	
Children's Helpline	$1,379,663
Family Navigators	$926,550
Total Other DBH-Funded Children's Services Expenses	**$2,306,213**
Grand Total DBH-Funded Children's Services	**$10,099,329**

Children's Services Spending by Region

The following tables provide regional breakdowns of the children's services spending by region

and service categories for SFY2014. There was wide variation in spending by region, with Region 6 reporting the greatest proportion of expenditures at 30% of the total. In contrast, Region 2 reported the smallest proportion of expenditures at just 8% of the total.

Table 17. Children's services spending by region, SFY2014

Region	Children's Services Expenditures
1: Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan and Sioux counties	$749,514
2: Arthur, Chase, Dawson, Dundy, Grant, Hayes, Hitchcock, Hooker, Frontier, Gosper, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow and Thomas counties	$638,781
3: Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster and Wheeler counties	$1,431,915
4: Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston and Wayne counties	$672,567
5: Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer and York counties	$1,910,110
6: Cass, Dodge, Douglas, Sarpy and Washington counties	$2,367,874
Total	**$7,770,761**

Table 18. Spending by region and service, SFY2014

Service	Region	Expenditures
Mental Health Services		
Youth Transitional Program/Transition Age PPP (Under 19)	1	$25,205
	3	$108,785
	5	$15,115
Professional Partner Program	1	$447,592
	2	$408,456
	3	$855,854
	4	$453,221
	5	$616,387
	6	$1,054,067

Service	Region	Expenditures
LB603 Professional Partner	1	$50,886
	2	$64,071
	3	$100,091
	4	$123,131
	5	$13,826
	6	$405,429
Professional Partner School Wraparound	1	$10,453
	4	$12,938
Professional Partner Peer	6	$24,376
Outpatient Therapy (Individual/Family/Group)	1	$123,260
	2	$108,282
	3	$142,485
	4	$15,870
	5	$447,394
	6	$558,273
Youth System Coordination	1	$22,590
	2	$42,861
	3	$114,753
	4	$16,859
	5	$15,972
	6	$95,349
Multisystemic Therapy (Home-Based)	3	$65,440
Medication Management	3	$2341
	4	$4,798
Therapeutic Consultation (P.L. 100-690)	3	$397
	5	$105,592
504 (P.L. 102-321)	3	$4,045
Prevention	5	$209,516
Youth Assessment	5	$251,900
Intensive Outpatient	5	$48,383
Crisis Response Teams (LB603)	6	$162,638

Service	Region	Expenditures
Respite Care	6	$46,091
Total MH Expenses		**$7,394,972**
Substance Use Disorder Services		
Outpatient Therapy (Individual/Family/Group)	1	$46,937
	3	$9,085
	4	$9,200
	5	$115,774
Youth System Coordination	1	$22,590
	2	$15,112
	4	$19,393
	5	$8,416
	6	$23,354
Intensive Outpatient	3	$28,639
	4	$16,579
Community Support	4	$578
	6	$21,651
Youth Assessment	5	$57,533
Family Support and Advocacy (Pilot)	5	$3,303
Total SUD Expenses		**398,144**
Subtotal DBH-Funded Children's Services through Regions		**$7,793,116**
Other Services		
Children's Helpline		$1,379,663
Family Navigators		$926,550
Total Other DBH Funded Children's Services Expenses		**$2,306,213**
Grand Total DBH-Funded Children's Services		**$10,099,329**

Total Served by Race, Age and Gender

Demographic data provided on the youth receiving DBH-funded BH services indicate the breakdown by race, age and gender as shown in the following tables.

Table 19. Children Served by Age and Gender, SFY2014

Age Group	Males in Community	Females in Community	Total	Males in Hospital-Based	Females in Hospital-Based	Total
0 – 12 years	661	351	1,013[103]	3	2	5
13 – 17 years	840	653	1,495[104]	94	2	96
18 – 21 years	1,782	1,181	3,283	100	35	135
Total	**3,283**	**2,185**	**5,471**	**197**	**39**	**236**

Community

There were some mild racial and ethnic differences between the populations served by DBH in community settings during SFY2014. DBH served a slightly higher proportion of African-American youth (15%) and American Indian or Alaskan Native youth (4%) relative to the racial and ethnic proportions across Nebraska statewide (5% and 1%, respectively). The proportion of white youth served by DBH during SFY2014 was close to the overall statewide proportion.

Table 20. Children Served in Community Settings by Race and Age Range, SFY2014

Race	Age Range			Total	2010 State Census Data
	0-12 years	13-17 years	18-21 years		
Asian-American					
Number	4	15	29	48	
Percentage	0.4%	1.0%	1.0%	0.9%	1.8%
African-American					
Number	70	106	250	426	
Percentage	6.9%	7.1%	8.4%	7.8%	4.5%
Multiracial					
Number	47	47	27	121	
Percentage	4.6%	3.1%	0.9%	2.2%	2.2%
American Indian/Alaska Native					
Number	33	41	117	191	
Percentage	3.3%	2.7%	3.9%	3.5%	1.0%
Native Hawaiian/Pacific Islander					
Number	5	21	33	59	

[103] Gender data was missing for one child in this age category.
[104] Gender data was missing for two children in this age category.

Race	Age Range			Total	2010 State Census Data
	0-12 years	13-17 years	18-21 years		
Percentage	0.5%	1.4%	1.1%	1.1%	<1%
Unknown					
Number	4	3	5	12	
Percentage	0.4%	0.2%	0.2%	0.2%	N/A
White					
Number	850	1,262	2,502	4,614	
Percentage	83.9%	84.4%	84.4%	84.3%	86.1%
Total	**1,013**	**1,495**	**2,963**	**5,471**	

Racial and ethnic differences were difficult to discern in the children served in hospital-based settings by DBH. Race/ethnicity was reported as other or unknown for 23% of those served.

Table 21. Children Served in Hospital-Based Settings by Race and Age Range, SFY2014

Race	Age Range			Total	State Census Data
	0-12 years	13-17 years	18-21 years		
Asian-American					
Number	0	0	3	3	
Percentage	0%	0%	2.2%	1.2%	1.8%
African-American					
Number	0	5	8	13	
Percentage	0%	5.2%	5.9%	5.5%	4.5%
Multiracial					
Number	0	1	3	4	
Percentage	0%	1.0%	22.2%	1.7%	2.2%
American Indian/Alaska Native					
Number	0	4	1	5	
Percentage	0%	4.2%	0.7%	2.1%	1.0%
Native Hawaiian/Pacific Islander					
Number	0	0	0	0	
Percentage	0%	0%	0%	0%	<1%
Other/Unknown					
Number	1	2	51	54	

Race	Age Range			Total	State Census Data
	0-12 years	13-17 years	18-21 years		
Percentage	20.0%	2.1%	37.8%	22.9%	N/A
White					
Number	4	84	69	157	
Percentage	80.0%	87.5%	51.1%	66.5%	86.1%
Total	**5**	**96**	**135**	**236**	

Living Situations of Children Served, SFY2014

The majority of children served by DBH were living with a parent or relative (50.2%), in a private residence without support (21.4%), or in a private residence with support (15.6%).

Table 22. Living situations of children

Living Situations	Total
Living with parent/relative	50.2%
Child residential treatment	0.1%
Crisis residential care	0.1%
Foster home	0.5%
Homeless/Homeless shelter	3.7%
Jail/Correctional facility	2.0%
Other 24-hour residential care	0.5%
Other institutional setting	0.2%
Other	3.1%
Private residence with housing assistance	1.1%
Private residence (receiving support)	15.6%
Private residence without support	21.4%
Regional center	0.0%
Residential treatment	0.6%
Youth living independently	0.7%
Blank/unknown	0.0%
Total	**100%**

A disproportionate amount (7%) of youth between the ages of 18 and 21 years were reported

to be homeless or living in shelters, compared to the proportion of all children and youth receiving DBH services who were homeless or living in shelters (3.7%).

Table 23. Homeless Persons or Homeless Living in Shelters Receiving Services, by Age, SFY2014

Age	Percent Homeless or Living in Shelters
0-12 years	0.3%
13-17 years	0.3%
18-21 years	6.6%
All age groups	3.7%

Division of Children and Family Services

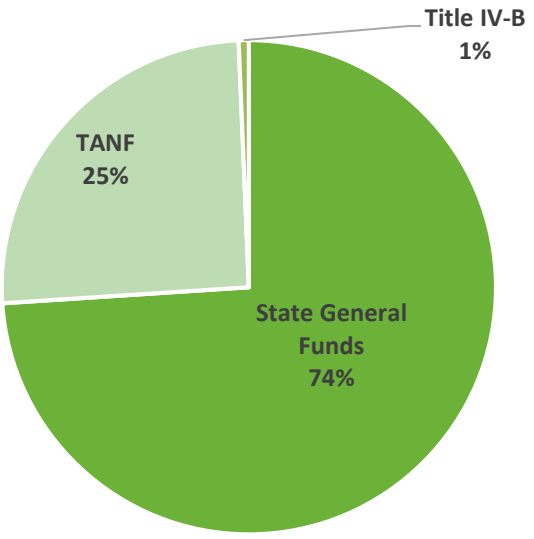
In collaboration with partners, the mission of the Division of Children and Family Services (DCFS) is to ensure that children are safe, healthy and have strong, permanent connections to their families. DCFS includes three sections: The Office of Juvenile Services, Economic Assistance, and Protection and Safety. The Protection and Safety Unit is responsible for Title IV-B Subpart 1 (Child Welfare Services), IV-B Subpart 2 (Promoting Safe and Stable Families), Title IV-E (Foster Care and Adoption Assistance), Child Abuse Prevention and Treatment Act (CAPTA), Chafee Foster Care Independence Program (CFCIP), and Chafee Education and Training Vouchers (ETV).

Nebraska's child welfare system is state-administered. It covers 93 counties organized into five service areas that are aligned with the Judicial Districts as set forth by the Supreme Court. The DCFS Protection and Safety Unit oversees the statewide child and adult abuse and neglect hotline, coordinates prevention activities and initiatives, develops policy, delivers child and adult case management and provides funding for services.

Funding Sources

Figure three illustrates the funding sources for community MH services provided to children and youth.[105] The majority (74%) of DCFS MH funding came from state general funds. These funds can be used as matching funds for Medicaid-eligible children receiving Medicaid-covered services, as well as for uninsured children. The remaining 26% of funding came from federal block grant funds, including TANF (25%) and Title IV-B (1%). These federal funding sources

Figure 3. DCFS Funding Sources for Community MH Services



[105] State funding data from SFY2015; Title IV-B data from FFY2014; funding year for TANF data unspecified.

cannot be used to match Medicaid. Currently available information does not provide the number of children and youth served by DCFS that have Medicaid nor the type of services received by Medicaid-eligible children, by funding source. The next steps in the analysis of funding is to identify the number of DCFS Medicaid-eligible children receiving services by type of service and payer source. This information is necessary to determine the full scope of state general funds that can be leveraged to obtain Medicaid reimbursements for children and youth who are eligible for Medicaid and receiving Medicaid-covered services.

Expenses

DCFS spent $100,513,800 in SFY2015 on services for youth during this time period, including residential care, out-of-home placements, and psychiatric and in-home services.

The table below provides a snapshot of expenses by category of service. Restrictive levels of care, which include PRFT and inpatient services, comprised the largest proportion of DCFS expenditures for SFY15 (80% of costs), followed by out-of-home services (14% of costs) and outpatient treatment (5% of costs).

Table 24. Spending and Utilization by Type of Service and Cost per Child, SFY2015

Service Type	Expenses	Youth Served	Average Cost per Child	Proportion of Expenditure by Service Type
Restrictive levels of care[106]	$5,015,107	78	$64,296	80.0%
Out-of-home services[107]	$845,550	24	$35,231	13.5%
Day treatment	$54,179	13	$4,168	.9%
Intensive outpatient	$72,792	35	$2,165	1.2%
Outpatient treatment[108]	$279,186	292	$956	4.5%
Total	**$6,266,814**	**442**	**$14,850**	

While spending on restrictive levels of care was the largest expenditure (80%), this only accounted for about 18% of all youth served by DCFS in SFY15 (see Table 25).

[106] Includes PRTF (hospital-based, specialized, and non-specialized) and inpatient.
[107] Includes ThGH and structured, out-of-home care.
[108] Includes psychotherapy (individual, group, and family).

Table 25. Count of Youth Receiving BH Services in Residential, Out-of-Home, and Community Settings, SFY2015

Service Type	Youth Served	Proportion of Youth Served
Residential services[109]	78	17.6%
Out-of-home services[110]	24	5.4%
Community/outpatient services[111]	340	76.9%
Total	**442**	

[109] Includes PRTF (hospital-based, specialized and non-specialized) and inpatient.
[110] Includes ThGH and structured, out-of-home care.
[111] Includes day treatment, intensive outpatient, and psychotherapy (individual, group, family).

Division of Developmental Disabilities

The Division of Developmental Disabilities (DDD) provides funding and oversight for community-based services for individuals with developmental disabilities (DD). The DDD also operates sites providing direct services for these individuals, determines eligibility for DD services, provides service coordination for eligible individuals, determines eligibility for DD Medicaid waiver services, regulates and pays providers of community-based developmental disability services, provides training and technical assistance, and investigates complaints. Currently available information does not provide the number of children and youth served by DDD that have Medicaid nor the type of services received by Medicaid eligible children by funding source. The next steps in the analysis of funding is to identify the number of DDD Medicaid-eligible children with MH conditions receiving services, by type of service and payer source. This information is necessary to determine the full scope of state general funds that can be leveraged to obtain Medicaid reimbursements for children and youth who are eligible for Medicaid and receiving Medicaid-covered services.

Total Served by Race, Ethnicity and Gender

Demographic data provided on youth receiving DDD-funded BH services indicate the breakdown by race, ethnicity, and gender as shown in the following tables. These tables compare the demographic proportions of children served by race, ethnicity, and gender in DDD-funded BH services to the general population of Nebraska.

As can be seen in Table 26, there were certain racial and ethnic differences between the DDD populations served during the time period represented by the data. DDD served a higher proportion of African-American youth (15%) and American Indian or Alaskan Native youth (3%) relative to percentages in the overall Nebraska population (5% and 1%, respectively). In comparison, 77% of white youth received DDD-funded BH services compared with the overall Nebraska population (86%).

Table 26. Total Served by Race and Ethnicity

Race/Ethnicity	Number	% of Total	2010 State Census Data
Race			
White (non- Hispanic)	223	77%	86.1%
African-American	44	15%	4.5%
American Indian/ Alaskan Native	8	3%	1.0%
Asian/Pacific Islander	4	1%	1.8%
Other	12	4%	N/A
Total	**291**		

Race/Ethnicity	Number	% of Total	2010 State Census Data
Ethnicity			
Non-Hispanic	170	58%	90.8%
Hispanic	13	4%	9.2%
Unable to Determine	14	5%	N/A
Unknown	94	32%	N/A
Total	**291**		

Additionally, there was a disproportionate number of males receiving community BH services funded by DDD. As seen in the table below, males comprised just under 50% of the general population of Nebraska during the time period represented by the data, yet 68% of all youth receiving DDD-funding community BH services during this time period were male.

Table 27. Total served by gender

Gender	Number	% of Total	2010 State Census Data
Male	197	68%	49.6%
Female	94	32%	50.4%
Total	**291**		

Division of Medicaid and Long Term Care

The Division of Medicaid and Long-Term Care (Medicaid) encompasses the Medicaid Program, Home and Community Services for Aging and Persons with Disabilities, and the State Unit on Aging. Specific to children and youth, Medicaid provides health care services and administers in-home and community-based services.

Spending and Utilization

The State Medicaid Division spent $95 million in SFY2014 on Medicaid-financed BH services for a monthly average of 155,478 BH managed care enrollees. The Medicaid services provided to children with BH challenges included inpatient psychiatric, MH clinic and MH rehabilitation options, as well as outpatient assessment, treatment, and community supports.

The table below provides a snapshot of these expenses with cost per youth breakdowns for the fee for service (FFS) expenditures. Medicaid provided BH services for 15,940[112] unduplicated, Medicaid-eligible children. The average cost per youth receiving BH services was $3,132. The largest FFS expenditure was for BH medications (74% of costs), which was provided to over 20,000 duplicated youth. Expenses for residential services (8% of costs) comprised the third largest proportion of Medicaid expenditures, but were utilized by only 1% of youth served.

Table 28. Spending and utilization by type of Medicaid service, SFY2014

Service	Expenditures	Youth Served[113]	Average Cost per Youth	Proportion of Expenditure by Service Type
Fee for Service (FFS) Expenditures				
BH Inpatient Acute Psych	$1,278,385	414	$3,088	2.6%
BH Adult Substance Abuse	$12,869	17	$757	<1%
BH Residential	$3,782,685	228	$16,591	7.6%
BH Day Treatment	$239,357	99	$2,418	<1%
BH Medicaid Rehab Option	$24,667	16	$1,542	<1%
BH Assessment	$1,995,290	9,403	$212	4.0%
BH Therapy	$5,089,361	10,452	$487	10.2%
Community Treatment	$265,279	302	$878	<1%

[112] This figure does not include youth who received BH medications, which was a duplicated count.
[113] This category includes youth ages 21 years and younger.

Service	Expenditures	Youth Served[113]	Average Cost per Youth	Proportion of Expenditure by Service Type
Aides				
BH Injectable Medications	$5,196	88	$59	<1%
BH Transportation	$172,512	1,691	$102	<1%
BH Medications	$37,052,634	20,482[114]	$1,809	74.2%
BH Other Services	$5,081	85	$60	<1%
BH Other Services (ECT)	$987	2	$493	<1%
Total	**$49,924,303**	**15,940[115]**	**$3,132**	
Full Risk BH Managed Care				
Capitation Payments	$45,770,864[116]	155,478[117]	N/A	
Grand Total	**$95,695,167**			

Institutional and Non-institutional Medicaid Spending

Approximately 10% of Medicaid BH-specific service expenditures were spent on institutional services, specifically inpatient psychiatric care, treatment in psychiatric residential treatment facilities (PRTFs), or in 24-hour residential care. In comparison, 90% of expenditures were spent on non-institutional care, including outpatient assessment and treatment, community supports, and clinic and rehabilitation services. Institutional care is generally more intensive and expensive than non-institutional care and is reserved for children and youth with severe psychiatric conditions.

Table 29. Institutional and Non-Institutional Medicaid Spending for Eligible Clients, SFY 2014

Category	Service	Expenses[118]	Proportion of Expenses
Institutional	Institutional inpatient psychiatric care[119]	$5,061,070	10%

[114] This figure includes duplicated recipients.
[115] This figure includes unduplicated recipients of FFS BH services, but not BH medications, for service dates 07/2013-6/2014.
[116] Expenditures include capitation payments incurred 9/2013-6/2014, plus any retroactive adjustments or reconciliations, and the portion of the Risk Corridor payment attributable to enrollees <21 years old.
[117] This figure includes the average monthly BH managed care enrollees <21 years old.
[118] Amounts include services paid for eligible clients from 9/01/2013-6/30/2014.
[119] Includes acute inpatient psych, PRTF, and 24-hour residential.

Category	Service	Expenses[118]	Proportion of Expenses
Non-institutional	Non-institutional BH-specific (excluding inpatient)	$44,863,233	90%
Total	**Total BH-specific services**	**$49,924,303**	**100%**

Division of Public Health

The Division of Public Health (DPH) brings together all of the elements of public health within the Nebraska Department of Health and Human Services. DPH is responsible for preventive and community health programs and services. It is also responsible for the regulation and licensure of health-related professions and occupations, as well as the regulation and licensure of health care facilities and services. DPH includes public health programs such as evidence-based home visiting; Women, Infants, and Children (WIC) program; Tobacco Free Nebraska; WISEWOMAN; initiatives through the Office of Health Disparities and Health Equity; and the Emergency Medical Services program.

Services

Table 30, below, lists the preventive and community health services that impact children and families. Specific utilization data is not available because of DPH's population-based health approach.

Table 30. Services

Nebraska Maternal, Infant, and Early Childhood Home Visiting Program	Funds
Federally Funded – By County	
Box Butte, Morrill, Scotts Bluff	$425,000
Lancaster	$439,000
Douglas	Implementation: $520,000 Coordinated Intake: $100,000
Total Federal Awards	**$1,484,000**
State Funded – By County	
Antelope, Burt, Cedar, Cuming, Dakota, Dixon, Dodge, Knox, Madison, Pierce, Stanton, Thurston, Washington, Wayne	Implementation: $141,273 Data Systems: $40,626
Lancaster	Implementation: $272,149 Data Systems: $11,460
Gage, Jefferson	Implementation: $323,347 Data Systems: $13,458
Douglas	Implementation: $201,449 Data Systems: $96,239
Total Appropriation for State General Funds	**$1,100,000**

Nebraska Children and Families Foundation

The Nebraska Children and Families Foundation (Nebraska Children) is a private foundation providing funding through the state for prevention, EBPs, PPs, and emerging practices that serve Nebraska's children, young adults, and families at risk.

Services Funded

Table 31, below, lists the Nebraska Children funding expended, by category of service or program.

Table 31. Nebraska Children Funded Services

Nebraska Children and Families Foundation Private Funds Expended, 2013-2014	
Funded Programs or Services	**Total**
Level I Emerging Practices	$147,537
Level II Promising Practices	$41,000
Level III Supported Practices	$215,347
Level IV Well-Supported Practices (HFA Technical Assistance)	$11,296
Prevention	$8,101,611
Total Spent	**$8,516,791**

Methodology

TriWest Group (TriWest) collected and studied utilization, expenditure, and financial data related to mental health and substance use disorder services provided to children and youth by Nebraska child-serving agencies during state fiscal years (SFY) 2014 and 2015. In order to facilitate data collection for this report's analysis, TriWest prepared a data request document that was submitted to each Nebraska Department of Health and Human Services Division and the Administrative Office of Probation, Juvenile Services (AOP JS) requesting information on the following categories:

- General information (e.g., strategic plan, description of service delivery plan),
- Behavioral health services,
- Populations served,
- Funding information for behavioral health services for children/youth and their families,
- Spending information.

In early July 2015, TriWest facilitated on-site meetings with representative from the DHHS Divisions of Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Public Health; the Administrative Office of Probation, Juvenile Probation Services; and the Nebraska Children & Families Foundation (State Entities) to engage them in the data request process, review the data request document, and address the logistics of submitting requested information. TriWest submitted additional follow-up data requests in January 2016 and received information from the State Entities.

TriWest began analysis of the data in February and March 2016, and conducted telephone interviews with the State Entities. Follow-up phone interviews were held on March 16, 2016 (with the Division of Developmental Disabilities), May 6, 2016 (with the Division of Children and Family Services), May 26, 2016 and June 17, 2016 (with the Administrative Office of Probation), and on June 24, 2016 (with the Division of Medicaid and Long-Term Care) to clarify submitted data and request additional information. TriWest also met bi-weekly with the Division of Behavioral Health's contract manager for the Financial Blueprint Report, and reviewed the State Entities' submitted materials during these meetings.

TriWest analyzed information provided by the State Entities, focusing on spending and utilization data by service type, level of care/service intensity, and race, ethnicity, and gender (to the extent this data was available). The cross-systems analysis of current funding sources, as well as types of service and levels of care, was essential for identifying:

- State general funds that Nebraska can leverage to generate federal funding;
- Any other third party insurance that providers can obtain;
- The types of child and youth services provided by Nebraska agencies, including any overlapping services or gaps in service provision;

- Resources that could be diverted from higher levels of care in order to encourage more community-based treatment options for children and youth rather than out-of-home placements, such as detention, foster care, PRTFs, group homes, and inpatient care;
- Mental health (MH) and substance use disorder (SUD) services available for children and youth in Nebraska and their sources of funding to determine which if any of those services could be leveraged to obtain federal reimbursement, or reimbursement from other third party insurers, thereby maximizing resources to better the lives of children and families.

The development of this report was supported by ongoing communication and input from the Division of Behavioral Health. Additional review of the data analysis and feedback from the State Entities was also provided. As a point in time study, the recommendations in this report will need to be reviewed in the context of any changes in service utilization since 2014.

Strengths and Limitations of Available Data

Data was collected by each state entity according to their mandates and data collection processes. Unique counts of children and families served were not available due to the limitations of the data systems. Data limitations are not unique to Nebraska and are common to cross-system data collection activities in which each entity operates under different regulators and reporting requirements. Also, not all services of each entity fit into the same definitions. TriWest identified where there were differences in definitions to the extent possible. Available data provided a snapshot in time as well as an initial pathway for identifying strategies for leveraging funding. The leveraging recommendations in this report will require review and decisions by the leadership of the State Entities.

Appendix One: Sample Flow of Intake, Service Planning, Authorization and Payment

Referral Sources:
Family
AOP-JPS
DBH
DCFS
DDD
DPH
School
Other

Care Management Entity/RBHA

- Intake and Wraparound coordination
- Arranges interim services (e.g., for 30 days) in collaboration with State Entities/providers
- Arranges for CANS/other assessments
- Obtains input from PCP, State Entities, school districts
- Arranges family/peer support
- Convenes Youth & Family Team
- Facilitates development of family-driven/youth-guided service plan
- Submits service plan for care authorization

Care Authorization Entity e.g., BHMCO/State Entities Authorization Team

- Authorizes service payments for interim 30 days until full service plan is development
- Reviews service plan for appropriateness
- May request additional information from Youth and Family Team
- Authorizes the services/payments based on payment hierarchy established by State Entities
- Notifies care management entity of service authorizations

Payment Hierarchy

- Medicaid pays for Medicaid covered service provided to Medicaid-eligible youth.
- Based on the youth's "eligibility" for DBH, DCFS, DDD or educational services, each of the State Entities and school districts pays for services within their mandates and budgets when the youth is not covered by Medicaid or other insurance, or pays for services to insured youth for services not covered by Medicaid or insurance.
- The allowable services and payment hierarchy rules have to be determined in advance among the State Entities, including payments for uninsured youth and for services not covered by Medicaid.
- Several states have selected a centralized BH managed care organization to authorize the services for payments, pay provider claims, and bill either Medicaid or the responsible State Entity for services.
- Other states set up state-operated payment systems, which typically requires changes to the MMIS.

TriWest

Appendix Two: DHHS and Partner Contributions to SOC Grant Application

Table 32. DHHS Contributions to NeSOC

DHHS Contributions to NeSOC
Division of Children and Family Services (DCFS)
✓ Child Welfare Waiver Demonstration Activities: Alternative Response & Results-Based Accountability ✓ Psychotropic Medication Management: Partnerships to establish guidelines, develop consent forms, create training/educational opportunities for child's treatment team, create a consultation process; comprehensive psychotropic medication review of current Nebraska foster children ✓ Trauma-Informed Care Workgroup: Development of a three-to-five year Trauma-Informed Care Strategic Plan to address the needs within DCFS; collaborating on the development of a Trauma-Informed Training Plan
Public Health
✓ State Health Improvement Plan: A blueprint for improving the public health system in Nebraska, finalized September 2013 ✓ Maternal, Infant and Early Childhood Home Visiting Program ✓ Promotion of early and regular screening for social emotional development in early childhood ✓ Development and support of systems for school-age children and youth
Medicaid & Long Term Care
✓ Medicaid Behavioral Health Services: Range of mental health and substance abuse services covered by Nebraska Medicaid through age 20, with over 20 services available ✓ Future Services: Nebraska Medicaid will amend the Medicaid State Plan to allow for payments for Multisystemic Therapy for youth who are eligible for Medicaid or CHIP ✓ Behavioral health modification coverage and behavioral health services for children and youth identified on the autism spectrum or with developmental disabilities disorders
Division of Behavioral Health (DBH)
✓ Promotes trauma-informed care through a statewide initiative, Trauma Informed Nebraska ✓ Youth summits to gain input for state suicide prevention strategic plan revision ✓ 18,464 trainees have taken advantage of the free suicide prevention resource available statewide to public schools ✓ Age waiver for youth ages 17 and 18 to receive services in adult behavioral health services ✓ Behavioral Health Education Center of Nebraska entered into a contract with several divisions within DHHS, including DBH, to coordinate implementation of trauma-informed care training and services ✓ Co-occurring disorders quality initiative to help promote recovery for individuals and families as well as integrating the co-occurring service delivery system

Table 33: Partner Contributions and Experience

NeSOC Partner Capability and Experience
NeSOC Foundational Partner: Administrative Office of Probation – Juvenile Services
Relevant Experience: Juvenile Detention Alternative Initiative (strengthen system through reform strategies), Cross-Over Youth (practices for reduction in crossover between welfare and juvenile justice), Family Engagement Capstone Project (increase youth/family engagement), Trauma-Informed Care (train probation personnel), BH partnership development (identify gaps, align service development).
Brings to the NeSOC Table: Connection to segment of population of focus. Vital/essential voice/participation in NeSOC Collaborative activities, principle member on local NeSOC teams. Shared vision for systems reform.
NeSOC Foundational Partner: NE Department of Education
Relevant Experience: Accreditation, approval, continuous improvement, and support of state's 245 public school districts; 192 non-public school systems; and 24 facility-based schools in residential treatment programs, emergency shelters, detention and correctional settings. Certification approval of 31,748 certificated school staff. Rules, regulations, and policies on education. Data, research, and evaluation.
Brings to the NeSOC Table: Access to a statewide network of educators for regional and local collaboration. Coordination and support from NDE's *Education of Systems-Involved Students Initiative* to improve outcomes for students in child welfare, juvenile/criminal justice, and behavioral health systems.
NeSOC Foundational Partner: NE Children and Families Foundation
Relevant Experience: Innovative programs and initiatives, including Youth Council Network, Project Everlast (Foster Care), Prevention Partnership (state-level planning), Rooted in Relationships (child social/emotional development), Child Well-Being Community Collaboration (community assistance), Beyond School Bells (community coalitions for expanded learning opportunities). Extensive experience in community development, coalition building and planning.
Brings to the NeSOC Table: Shared "systems" philosophy. Connection to youth and families for NeSOC engagement. Developed networks with state and community leaders. Statewide identity and recognition.
NeSOC Foundational Partner: University of Nebraska, Public Policy Center
Relevant Experience: Conducted 2013-2014 NeSOC needs assessment. Extensive experience collecting/reporting SAMHSA data and using TRAC system. On-going involvement in related BH projects, including Suicide Prevention grant. Established network of policymakers and researchers dedicated to sound evaluation and QI practices.
Brings to the NeSOC Table: NeSOC evaluation contractor. Provides recommendations to NeSOC Collaborative Leadership Board. Established statewide evaluation channels within school districts and behavioral health regions.
NeSOC Foundational Partner: DHHS Office of Health Disparities and Health Equity
Relevant Experience: Serves state constituencies to improve health outcomes, including mental and behavioral health, among state, regional, and local minority populations. Extensive history of collaborations and partnerships both intra- and inter-agency, bringing about awareness, identification of needs, and targeted initiatives to address disparity/equity issues.

NeSOC Partner Capability and Experience
Brings to the NeSOC Table: Expertise in CLAS and disparity/equity issues. Provides liaison to tribal populations. Provides relevant information to NeSOC Collaborative at all levels.
NeSOC Foundational Partner: Regional Family Organizations
Relevant Experience: Extensive collaborations in each of the state's six behavioral health regions around common issues affecting families. Developed network of family and youth voices; experience with disability and the child-serving agencies.
Brings to the NeSOC Table: Lends youth and family voice to the development and implementation of NeSOC. Provides connections to youth and family peer support programs.

Appendix Three: Federal Financing Sources for Children's Services

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB May 11, 2016	Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children.	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf This bulletin provides guidance for state Medicaid agencies to assist them in covering maternal depression screening as part of a well-child visit, even when the mother is not Medicaid eligible. Because maternal depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit. It reiterates that states must cover any medically necessary treatment for the child as part of the EPSDT benefit. Due to the prevalence of material depression (40 to 60 percent of low-income women have some type of depression), and its significant early risk to child development, the mother-infant bond, and the family, Medicaid may pay for depression screening. The bulletin cites the American Academy of Pediatrics and indicates that screening mothers for maternal depression is a best practice for primary care pediatricians caring for infants and their families and can be integrated into the well-child care schedule and the prenatal visit. If the screening for depression is positive, diagnostic and treatment services directed solely at the mother would be covered under Medicaid if the mother is Medicaid eligible. However, mothers who are not Medicaid-eligible "may receive some benefit from diagnostic and treatment services directed at treating the health and well-being of the child: (such as family therapy services) to reduce or treat the effects of the mother's condition on the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child." The bulletin indicates "such services must be covered under a 1905(a) benefit such as rehabilitative services or other licensed practitioner services."

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
SHO # 16-007 April 28, 2016	To Facilitate successful re-entry from individuals transitioning from incarceration to their communities	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf This letter provides guidance on facilitating access to covered Medicaid services for eligible individuals prior to and after a stay in a correctional institution and is relevant for children/youth. "While Medicaid statute limits payment for services for individuals while residing in correctional institutions, Medicaid coverage can be crucial to ensuring a successful transition following incarceration. Inmates of a public institution who are held involuntarily may be enrolled in Medicaid, but may not receive Medicaid covered services. The inmate coverage exclusion applies to Medicaid services to inmates, except as inpatients in a medical institution as provided in statute and described in Section 3 of this document." This document clarifies the following: • Individual on parole, probation or released to the community pending trial (including those under pre-trial supervision are not considered inmates and if otherwise eligible for Medicaid, can receive covered services. • FFP is available for covered services for Medicaid-eligible individuals living in state or local corrections-related supervised community residential facilities (whether operated by a governmental entity or a private entity) unless the individual does not have freedom of movement and association while residing at the facility. • Individuals on home confinement (private place of residence) can receive covered Medicaid benefits. • The coverage exclusion for Individuals **voluntarily and temporary** living in a public institution, pending other arrangements does not apply. • This letter has other examples of related to suspension of Medicaid, access to services, managed care capitation payments and other financing rules for incarcerated individuals.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB October 16, 2015	Coverage of Early Intervention Services for First Episode Psychosis	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf This bulletin discusses the design of benefit packages for youth with first episode psychosis and notes: "Untreated psychosis increases a person's risk for suicide, involuntary emergency care, and poor clinical outcomes. Often individuals experience long periods of untreated psychosis and treatment delays are between one and three years following the onset of psychotic symptoms. …Early intervention can alter this illness trajectory and enable individuals …to live in community settings and participate fully in family and community life." The bulletin continues to describe integrated, team-based mental health services that reduce the severity of first episode psychotic symptoms, keeping individuals in school or at work. The team-based model, Recovery After an Initial Schizophrenia Episode (RAISE), was used in NIMH research to develop, test, and implement Coordinated Special Care (CSC) programs for use in real world community clinics. The research found that participants in CSC had great improvements in total symptoms, social functioning, work or school, and overall quality of life. This is an important finding, especially for older adolescents and young adults when the first onset of schizophrenia occurs. The treatment elements are consistent with many recovery-oriented services for adults and include: team based care, recovery-oriented psychotherapy, family psychoeducation and support, supported employment services, supported education services, pharmacotherapy and primary care coordination, and case management. Guidance from the bulletin discusses Medicaid reimbursements for these services, including 1904(a) authority under the State Plan; use of other licensed practitioner authority (1905 (a)(6) services); preventative and rehabilitation services (section 1905(a) (13)(c) and (d)); and section 1905 (a)(19) (as defined in section 1915(g)(2) – case management services). These services will need to be configured similar to ACT. In addition, Targeted Case Management, prescription drugs, and EPSDT benefits can support these services. Home and Community Based Services authorities (1915 (c), 1915 (i) and 1115 waivers) allow states to design community-based services for individuals who meet an institutional level of care, as long as the community-based services do not cost more than institutional services (cost neutrality). Use of these Medicaid authorities does not constitute an expansion of Medicaid. Rather, it realigns services that have proven outcomes for a specific population. With the right combination of authorities, treatment for first episode psychosis can be targeted to older adolescents and young adults.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB 6-25-2015 June 26, 2016	Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf The purpose of this Bulletin is to highlight emerging Medicaid strategies for preventing opioid-related harm. It provides background information on overdose deaths involving prescription opioids, describes several Medicaid pharmacy benefit management strategies for mitigating prescription drug abuse and discusses strategies to increase the provision of naloxone to reverse opioid overdose, thereby reducing opioid-related overdose deaths. Wherever possible, the bulletin provides examples of methods states can use to target the prescribing of methadone for pain relief, given the disproportionate share of opioid-related overdose deaths associated with methadone when used as a pain reliever.
Joint SAMHSA CMS Informational Bulleting January 26, 2015	Coverage of Behavioral Health Services for Youth with Substance Use Disorders	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf This informational bulletin, based on evidence from scientific research and the results of a Substance Abuse and Mental Health Services Administration (SAMHSA)-supported technical expert panel consensus process, is intended to assist states to design a benefit that will meet the needs of youth with substance use disorders (SUD) and their families and help states comply with their obligations under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. The services described in this document are designed to enable youth to address their substance use disorders, to receive treatment and continuing care and to participate in recovery services and supports. This bulletin also identifies resources that are available to states to facilitate their work in designing and implementing a benefit package for these youth and their families. It discusses the components of a continuum of services and supports: Screening, Assessment, Outpatient Treatment (individual, group and family therapy), Intensive Outpatient Treatment, Partial Hospitalization, and Medication-Assisted Treatment, Case management/Targeted Case Management, Continuing Care, Recovery Services and Supports, and Residential Treatment. The bulletin provides examples of screening tools and CMS authorities in use in other states to finance SUD services including 1905 (a), EPSDT, 1915(b) Authority, 1915(c) Authority, 1915(i) State Plan Amendments and 2703 Health Homes.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
SMD #15-003, July 27, 2015	New Service Delivery Opportunities for Individuals with a Substance Use Disorder	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf The purpose of this letter is to inform states of opportunities to design service delivery systems for individuals with substance use disorder (SUD), including a new opportunity for demonstration projects approved under section 1115 of the Social Security Act (Act) to ensure that a continuum of care is available to individuals with SUD. Section 1115 demonstration projects allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. States may receive federal financial participation (FFP) for costs not otherwise matchable, such as services delivered to targeted populations, in limited geographic areas, or in settings that are not otherwise covered under the Medicaid program. CMS recently launched the Medicaid Innovation Accelerator Program. The Innovation Accelerator Program supports state efforts to accelerate Medicaid innovations by offering technical assistance and expert resources to states engaged in Medicaid system redesign efforts. Based on our work with states and stakeholders, CMS identified SUD as the first area of focus for the Innovation Accelerator Program. As part of a strategy to improve the care and health outcomes and reduce costs for individuals with a SUD, CMS has begun engaging states to leverage IAP resources to introduce system reforms that better identify individuals with a SUD, expand coverage for effective SUD treatment, and enhance SUD practices to effectively treat beneficiaries. Participation in the Innovation Accelerator Program is not a requirement for introducing SUD system reforms through the Medicaid authorities discussed in this letter.
CIB July 7, 2014	Clarification of Medicaid Coverage of Services to Children with Autism	Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf This important bullet focuses on services for children with autism spectrum disorder (ASD). It also reinforces CMS rules for EPSDT benefit requirements and stipulates that "States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral health conditions."[120] These service categories include services of other licensed practitioners, preventive services, and therapy services. It is important to understand the requirements of this bulletin and opportunities that the State may want to implement.

[120] CMCS Informational Bulletin. (2014, July 7). Clarification of Medicaid Coverage of Services to Children with Autism.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
DHHS State Director Letter, July 11, 2013 SMD-13-07-11	Trauma	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-07-11.pdf This guidance letter is intended to encourage the integrated use of trauma- focused screening, functional assessments and evidence-based practices (EBPs) in child-serving settings for the purpose of improving child well-being. The Department of Health and Human Services' (HHS) Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) are engaged in an ongoing partnership to address complex, interpersonal trauma and improve social-emotional health among children known to child welfare systems. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. In addition to these traumatic events, a child's experience of these events can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. These adverse effects can include a child's physiological responses; emotional responses; ability to think, learn, and concentrate; impulse control; self-image; and relationships with others. Across the life span, complex trauma is linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors and other psychiatric disorders. Medicaid is an important source of reimbursement for services and support to children and youth who have experienced complex trauma and have behavioral health needs requiring treatment. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is Medicaid's comprehensive preventive child health service designed to make health care services available and accessible and to assist eligible children and their families in effectively using their health care resources. The preventive thrust of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early, before problems become more complex and their treatment more costly. EPSDT benefit requirements apply to Medicaid-eligible children under age 21, and include Medicaid reimbursement for covered services. The letter further discusses the interplay between child trauma and psychotropic medications, components of a cross-system approach for promoting child well-being, mainly integrating screening, assessment, referrals and interventions; and other financial resources in addition to Medicaid, for addressing child traumas (Child Welfare IB-b and IV-E authority and financing, discretionary grants and Mental Health and Substance Abuse Block Grants).

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB 03-27-13 March 27, 2013	Prevention and early Identification of Mental Health and Substance Use Conditions	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin to help inform states about resources available to help them meet the needs of children under EPSDT, specifically with respect to mental health and substance use disorder services. Effective mental health support for the more vulnerable comes from early identification. One of the most vulnerable classes is youth, recent studies indicate "that half of all lifetime cases of mental illness or substance use begin by age 14". Combined with higher than average illicit drug use the need for early screening becomes increasingly valuable. Keeping overall system costs low before they reach more expensive methods and increasing the overall health of a diagnosed individual. It is important that appropriate screening tools and quality clinical reporting are used in a clinical fashion to identify children and adolescents with mental and/or substance use conditions. Coupled with appropriate tools is effective professional development, taking advantage of many professional associations' commitment to more effective treatment.
CMS, SAMHSA, CDC, and NIH Joint Bulletin July 11, 2013	Medication-Assisted Treatment for Substance Use Disorders	Available at: http://www.samhsa.gov/sites/default/files/topics/behavioral_health/medication-assisted-treatment-joint-bulletin.pdf The purpose of this Bulletin is to highlight the use of FDA-approved medications in combination with evidence-based behavioral therapies, commonly referred to as "Medication-Assisted Treatment" (MAT), to help persons with SUDs recover in a safe and cost-effective manner. Specifically, the Bulletin provides background information about MAT, examples of state-based initiatives, and useful resources to help ensure proper delivery of these services. Medication-assisted treatment is the use of FDA-approved medications in combination with evidence-based behavioral therapies to provide a whole-patient approach to treating SUDs. It focuses on use of medications to assist with opioids and alcohol use and behavioral therapies, screening and strategies to implement and managed use of MAT. The bulletin also describes SAMHSA Treatment Improvement Protocols.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
Joint Bulletin May 7, 2013	Coverage of BH Services for Children Youth, and Young Adults with Significant Mental Health Conditions Children and Youth with Significant BH Conditions	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf This Informational Bulletin is intended to assist states to design a benefit that will meet the needs of children, youth, and young adults with significant mental health conditions. Children with significant emotional, behavioral and mental health needs can successfully live in their own homes and community with the support of the mental health services described in this document. These services enable children with complex mental health needs – many of whom have traditionally been served in restrictive settings like residential treatment centers, group homes and psychiatric hospitals – to live in community settings and participate fully in family and community life. The bulletin provides guidance on the research as well as on financing services through Medicaid: Intensive Care Coordination: Wraparound, Parent and Youth Peer Support; Mobile Crisis Response and Stabilization Services including residential crisis stabilization; Flex Funds, Trauma, and Other Home and Community Based Services. 1905(a) Authority, 1915(c) Authority, 1915(b) Authority, 1115 Authorities, 1915(I) State Plan Amendment, Section 2703 Health Homes, and Money Follows the Person Rebalancing Demonstration (MFP), which is good for providing intensive services after discharge from PRTFs; and the Balancing Incentive Program.
CMCS May 1, 2013	Clarifying Guidance on Peer Support Services Policy	Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf This document is used to clarify and provide addition content for the use of peer support services, intentionally widening the scope of peer support services to adults and Medicaid qualifying adults whose children are receiving peer support services. The bulletin suggests an increased scope of services provided by a peer support service (including but not limiting to) instilling confidence, assisting the development of goals, and being a mentor.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB-12-03-12 December 3, 2012	Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders	Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf The purpose of this CMCS Informational Bulletin is to provide information regarding services and good practices for individuals with a behavioral health disorder (mental health and substance use disorders). CMS is encouraged with the increased interest by states to develop effective strategies for developing benefit designs for this population. Many states have included behavioral health services for these individuals in the state plans and various Medicaid managed care waivers. More recently, states are considering or have taken advantages of new opportunities offered through the health Home program, Money Follows the Person program, Balancing Incentive Program and the revised section 1915(i) Home and Community-Based Services state plan option. Looking forward, states will have more opportunities to develop good benefit design as a result of the Mental Health Parity and Addictions Equity Act (MHPAEA) and benchmark plan for individuals in the Medicaid expansion population. Given this interest, we are releasing a series of Informational Bulletins that will provide additional information regarding services and supports to meet the health, behavioral health and long-term services and support needs of individuals with mental health or substance use disorders. Included with the extensive background is the formation of coverage goals that are intended to guide the development of current and future services for behavioral health.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB-11-28-12 November 28, 2012	Inpatient Psychiatric Services for Individuals Under Age 21	Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-11-28-12.pdf This Informational Bulletin clarifies that states may structure coverage and payment for the benefit category of inpatient psychiatric hospital or facility services for individuals under age 21 to ensure that children receiving this benefit obtain all services necessary to meet their medical, psychological, social, behavioral and developmental needs, as identified in a plan of care. This clarification is intended to describe flexibility currently available to states to ensure the provision of medically necessary Medicaid services to children in inpatient psychiatric facilities. It continues by clarifying the relationship between section 1905(a) of the Social Security Act (the Act) and section 1905(a) (16) of the Act. Stating that "a general hospital with a psychiatric program that meets the applicable conditions of participation" is able to provide to individuals under 21 under Medicaid claims. Recently, several Departmental Appeals Board decisions have clarified that other covered services can be furnished as part of the inpatient psychiatric facility benefit even when payment was made to an individual practitioner or supplier other than the inpatient psychiatric facility itself, when such services are furnished to a child residing in such a facility, authorized under the child's plan of care, and provided under an arrangement with the facility. In essence, the Departmental Appeals Board indicated that payment for such services does not need to be bundled into a single per diem rate for the IMD facility, but could be authorized under the approved State Plan to be paid directly to the treating practitioner. In light of these decisions, CMS is currently applying this flexibility in the approval of state plan amendments, and seeks to clarify the ability that states have in covering and paying for a more robust benefit for children receiving the inpatient psychiatric facility benefit.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
	Inpatient Psychiatric Services for Individuals Under Age 21, continued	States have a number of options in electing a methodology in their Medicaid State Plans to pay for the inpatient psychiatric facility benefit. Traditionally, many states make a direct payment to the facility through either an all-inclusive per diem rate or a base per diem rate with add-on payments. Under this direct payment method, if the facility obtains services under arrangement with outside providers, the facility would be responsible for paying the providers of the arranged services. An option that may be more flexible, and has been approved in state plan amendments, is to directly reimburse individual practitioners or suppliers of arranged services using payment methodologies that are applicable when the services are otherwise available under the State Plan. States electing this option would pay the same fees to such practitioners or suppliers as would otherwise be applicable when the services are furnished to Medicaid beneficiaries outside the inpatient psychiatric facility benefit. This option would allow states greater ability to capture potential efficiencies, and monitor the quality of care, through the use of existing delivery and billing processes. States electing to make separate payments under this option will need to assure there is no duplication of payment between the inpatient facility rate and the items paid for separately using existing state plan fees.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
CIB 08-24-12 August 24, 2012	Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations	Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-08-24-12.pdf The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin to inform states about additional opportunities and resources to address the use of psychotropic drugs in vulnerable populations. The collaborative efforts and technical assistance resources highlighted in this bulletin provide states with additional tools and mechanisms to promote the appropriate use, and enhance oversight of, psychotropic medications for children in foster care and individuals living in nursing facilities This bulletin encourages stronger oversight of the prescription of psychotropic medications through stronger collaborative networks, advocating for clinically alternative strategies, and further facilitate State development of current oversight plans. State awareness has increased on the issue and the exchange of newer requirements for psychotropic medications for children of young age have emerged. Also noted is "Some states have opted for a different approach and developed a comprehensive program composed of a multi-disciplinary team that works in partnership with other state agencies and/or works in concert with academia…to review cases and ensure that the patient is getting the appropriate combination of psychosocial and medical care." With this the acknowledgment of a "biopsychosocial" issue has encouraged more holistic approaches to tackle all faucets of a mental illness diagnosis.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
SMD-11-23-11 November 23, 2011	2011 Safe, Appropriate, and Effective Use of Psychotropic Medication Among Children in Foster Care	Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf The Department of Health and Human Services (HHS) has become increasingly concerned about the safe, appropriate, and effective use of psychotropic medications among children in foster care. In the coming months, the Administration for Children and Families (ACF), the Centers for Medicare and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) will offer expanded opportunities to States and territories (hereafter States) to strengthen their systems of prescribing and monitoring psychotropic medication use among children in foster care. Included in these opportunities will be a convening of directors of State child welfare, Medicaid, and mental health authorities to develop action plans for addressing this issue. There is still a struggle with positive outcomes for children in foster care who come from backgrounds of "complex social-emotional, behavioral, and mental health problems." When a recent study of 16 states stated "children in foster care environments are nine times more likely to be prescribed antipsychotic medications" the question of better oversight of these medications became necessary. This falls in line with The Fostering Connections to Success and Increasing Adoptions Act of 2008 as well as the Child and Family Services Improvement and Innovation Act of 2011. It is known that children in the child welfare system are at a higher risk of being diagnosed with mental health disorders than those of the general population, the increased frequency of prescribed antipsychotic medication is emphasized by factors of age, gender, behavioral concerns, and placement type. While the HHS wants to promote the use of evidence-based treatment, the current lack of polypharmacy study on children, the exploration of alternative combinations of treatment is encouraged.

Federal Communication / Letter #	Topic	Summary* *Please refer to the source document to obtain a full understanding of the requirements.
SMDL #07-11 August 15, 2007	Peer Support Services	Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers. The key areas for consideration are as follows (1) Supervision must be provided by a competent mental health professional (2) Care-Coordination, focusing on "person-centered planning process to help promote participate ownership of the plan of care." This is to increase the effectiveness of care plans and increase total benefits to be gained from such a plan. Lastly, (3) training and credentialing to be coordinated by the state to promote "competencies necessary to perform peer support function. States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date: • Section 1905(a)(13) • 1915(b) Waiver Authority • 1915(c) Waiver Authority