

*Evidence-Based Practices for Delinquent Youth with
Mental Illness in Maryland:
Medicaid Must Cover These Cost Effective Services*



*A Public Report by the Maryland Disability Law Center
January 31, 2007*

MDLC
MARYLAND DISABILITY LAW CENTER

About This Report

This report was prepared by the staff of the Maryland Disability Law Center (MDLC), the protection and advocacy system for people with disabilities in Maryland. The report was authored by Cathy S. Surace and Eileen Canfield. The preparation of this report was made possible by grants from the Jacob and Hilda Blaustein Foundation and the Aaron Straus & Lillie Straus Foundation.

For additional information or copies of this report, please contact:

Cathy S. Surace
Managing Attorney
Maryland Disability Law Center
1800 North Charles Street, Suite 400
Baltimore, MD 21201
(410) 727-6352
www.mdcbalto.org
cathys@mdcbalto.org



Executive Summary

To reduce juvenile violence and delinquency, save money, and comply with federal law, Maryland must cover three evidence-based practices for delinquent youth with mental illness under its Medicaid Program. Every year more than 30,000 children are arrested and enter Maryland's Juvenile Justice System.¹ Approximately 20-25% of these children have serious mental health disorders and up to 70% have a diagnosable mental illness.² Although the Maryland Department of Juvenile Services (DJS) and Mental Hygiene Administration (MHA) are paying a high price tag for thousands of delinquent youth to be placed in residential settings, that expensive care does not substantially reduce the risk of them again committing a crime. Approximately 66% of these youth will be re-arrested within two years after their release and 76% will be re-arrested within three years.³

The Department of Legislative Services has questioned whether some of these youth belong in DJS custody and recommended diverting them from the juvenile justice system for quicker and more effective mental health treatment.⁴ Such treatment exists on a small scale in Maryland in the form of evidence-based practices (EBPs) that have been subject to two decades of scientific study and found to have positive outcomes for youth and be more cost effective for states. Three of the most recognized EBPs, Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Multidimensional Treatment Foster Care (MTFC), are time-limited community-based interventions that can help youth with mental illness who are now served by DJS or at risk of entering their system. If Maryland widely implemented these three EBPs by covering them under the Medical Assistance Program, it would save a significant amount of money and transform the lives of many youth now on the path toward a life of criminal activity and failure.⁵

- **Functional Family Therapy (FFT)** is a type of family therapy provided either to delinquent youth or those at risk of delinquency for 3 to 5 months in a clinic or at home and costs approximately \$2,000 per child.
- **Multisystemic Therapy (MST)** is for youth at risk of out-of-home placement or transitioning back to the home who have actually engaged in delinquent, anti-social or substance abusing behaviors. The goal is to develop independent skills among parents and youth to cope with family, peers, school, and neighborhood problems through a period of brief (3 to 5 months) but intense treatment (24/7 therapist availability and 60 hours of contact) that takes place not in an office but in the child's home, school and community. Costs in Maryland range from \$5,000 to \$8,000 per child.
- **Multidimensional Treatment Foster Care (MTFC)**, in contrast to regular foster care or typical treatment foster care, places children singly or with one other child in a very structured and professionally supported foster home for 6 to 9 months while engaging the family to which the child will return in weekly therapy and parent training. Cost estimates are approximately \$26,000 per child.

The impact of these programs in Maryland has been limited by their short-term funding and availability only in a small number of jurisdictions. MTFC is not available at all. Even where FFT and MST are available, children have been placed on waiting lists and

programs struggle to find new funding streams when grants end. Only a handful of the children who could benefit from these practices now are able to access them. The State has not added these EBPs as covered services in its State Medicaid Plan, which would enable it to maximize their availability to children across the State while receiving a 50% federal funding match. When children who might have avoided DJS involvement had they received these EBPs enter the juvenile justice system, they lose their eligibility for Medicaid if placed in secure residential settings, and the State must foot the entire bill for expensive mental and somatic health care in addition to their residential placement.

The failure to include these EBPs as covered Medicaid services is not only an unwise state policy but it also raises a serious legal problem for Maryland. FFT, MST, and MTFC are approved treatments in many state Medicaid Programs eligible for federal reimbursement. This means that the federal Center for Medicare and Medicaid Services has determined that they are health care services *covered* by the federal Medicaid Act. Under Medicaid's Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) mandate, any enrollee under age 21 must have access to all medically necessary health care services that could be covered by the Medicaid Program. By not providing these services in Maryland, the Medicaid Program is vulnerable to a legal challenge.

Not only is Medicaid coverage of these EBPs a legal mandate, it is also a practical necessity. Without Medicaid coverage, Maryland cannot maximize their availability for the children who need them and sustain funding for these programs. Medicaid funds *more than half* of public mental health services administered by states and is estimated to account for two-thirds of such spending by 2017.⁶ Medicaid dollars account for an even greater percent of the spending on children's mental health services by Maryland's Mental Hygiene Administration (MHA). In FY 2006, approximately 94% of MHA's spending on children's services came from state and federal Medicaid dollars.⁷ Therefore, Medicaid must be part of maximizing the use of EBPs in Maryland since otherwise, there will only be small, time-limited grant funded opportunities that the State simply cannot sustain over time.

This report is organized to:

- Provide an overview of evidence-based practices for delinquent youth with mental illness;
- Describe the mental health services that have been provided by the Mental Hygiene Administration and the Department of Juvenile Services to this population;
- Detail the scarcity of these EBPs in Maryland compared to the growing number of states using Medicaid to cover these practices;
- Detail the evidence of the cost-effectiveness of these EBPs;
- Describe recent government efforts to expand EBPs in Maryland; and
- Explain federal law dictating that these services must be covered by the Maryland Medical Assistance Program.

MDLC's goal is to make it clear that from a policy perspective, a cost perspective, and a legal perspective, Maryland should act now to add MST, FFT and MTFC to its array of Medicaid services for youth with mental illness. We recommend the following action:

- The Department of Health and Mental Hygiene's (DHMH) Medicaid Division and the Mental Hygiene Administration should submit a State Plan Amendment to the Center for Medicare and Medicaid Services by June 30, 2007 for approval to cover Multisystemic Therapy (MST) under the State Medicaid Plan.
- DHMH's Medicaid Division and the Mental Hygiene Administration should submit a State Plan Amendment to the Center for Medicare and Medicaid Services by December 31, 2007 for approval to cover Functional Family Therapy (FFT) under the State Medicaid Plan or make a determination that FFT will be billed as a Medicaid service under an existing billing code as other states have done.
- Maryland should develop a Multidimensional Treatment Foster Care (MTFC) component of its existing treatment foster care service that is already part of the State Medicaid Plan by December 31, 2007.
- Following approval by the federal government of the submitted State Plan Amendment to cover MST and, if necessary, FFT, DHMH should immediately draft regulations on MST and FFT.
- DHMH's Medicaid division should work with the Mental Hygiene Administration, the Department of Juvenile Services, and the other agencies serving children to draft a Memorandum of Understanding that details a cost sharing arrangement to pay the state share of the costs for MST, FFT and MTFC.
- In implementing these practices under Medicaid, DHMH should maintain strict model fidelity to these EBPs.
- The General Assembly should require state agencies to take the above actions if they have not done so by January 1, 2008.

Overview of Evidence-Based Practices for Children with Mental Illness

History and Support

Evidence-based practices (EBPs) are interventions for which there is consistent scientific evidence showing that they improve client outcomes. Studies have shown that they produce the defined, expected outcomes that they are intended to produce when implemented with fidelity to the model program.⁸ Because they adhere strictly to a particular program model, they are more structured and standardized than traditional mental health services. These programs were developed to address several limitations of existing mental health services for delinquent and at risk youth, including minimal effectiveness, low accountability of service providers for outcomes, and high cost.⁹ These are problems that Maryland's juvenile justice system is grappling with and that the Mental Hygiene Administration also has noted with respect to its funding of children's mental health services.

As the number of youth involved in violent, delinquent activity continued to rise and the adequacy of services available to help these adolescents was questioned, public and private entities began to study new and existing juvenile mental health programs. In 1996, the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado launched a national violence prevention initiative to identify violence prevention programs that are effective. The project, called Blueprints for Violence Prevention, identified eleven programs that meet a strict scientific standard of program effectiveness. The eleven model programs have been effective in reducing adolescent violent crime, aggression, delinquency, and substance abuse.¹⁰ These model programs include the three mental health services that are the subject of this report.¹¹

Similarly, the United States Department of Justice rated youth violence prevention programs and identified ten which met a “gold” standard of proven program effectiveness. MST, FFT and MTFC were among them.¹² The United States Surgeon General in its 2001 report on youth violence also rated MST, FFT and MTFC as “model” programs. To meet this high standard a program had to show that it has a significant, sustained preventive or deterrent effect and that it can be expected to have positive results in a wide range of community settings, as long as it is implemented correctly and with the appropriate population.¹³

Finding after finding on juvenile violence and delinquency prevention programs name the three EBPs that are the subject of this report as among the most valuable tools in helping this population of adolescents.¹⁴ While there are other promising practices to address the needs of delinquent youth with mental illness, these three practices are true evidence-based practices that have been subject to scientific scrutiny and determined to be effective.¹⁵ They are not recommended as a model to treat all children with mental illness *or* children whose primary need is for psychiatric treatment rather than services to address their delinquent behavior.¹⁶ In fact, to be eligible for these practices, a child need not have any mental illness diagnosis at all.¹⁷ Rather, their focus is limited to youth with delinquent or anti-social behavior who are more likely to have a behavioral disorder diagnosis, such as Attention Deficit Disorder, Mood Disorder or Oppositional Defiant Disorder, than a severe mental illness. These practices can be viewed on an intensity and cost continuum, with FFT being the least intensive and least costly treatment, then MST, and then MTFC.

Functional Family Therapy (FFT) is a type of family therapy provided in clinic settings and in the home that generally targets youth ages 11 to 18 that present with problems in delinquency, violence and substance use or are *at risk of these problems*. It is a time-limited intervention for 3 to 5 months that incorporates specific phases or steps during the treatment.¹⁸ Interventions range from, on average, 8 to 12 one hour sessions for mild cases and up to 30 sessions for more difficult situations. Each FFT program site is trained and supervised using a similar protocol, implements the same clinical model, and engages in monitoring and outcome assessment. Costs for the program per youth reported in 2003 range from \$1,300 to \$3,750, while recent costs for Maryland sites have been about \$2,000.¹⁹

In multiple clinical trials, FFT achieved significant reductions in the proportion of youth who re-offended and the frequency of offending up to 2 ½ years after participation in the service. Positive effects on the siblings of youth receiving FFT have also been observed, with significantly fewer siblings than control youth having juvenile court records 2 ½ and 3 ½ years after the program.²⁰

Multisystemic Therapy (MST) is a family and community-based intervention for youth between 12 and 17 years old with serious antisocial or delinquent behavior who are at risk for out-of-home placement or transitioning back from an out-of-home setting.²¹ To be eligible, youth need not already be in the juvenile justice system but must actually be engaging in behaviors that would warrant arrest. The primary goal is to develop independent skills among parents and youth with behavioral problems to cope with family, peers, school, and neighborhood problems through a period of brief but intense treatment.²² MST occurs not in an office setting but in the youth's natural environment (e.g., home, school, and community) and proceeds through a treatment plan that has been developed in collaboration with family members.²³ It requires that the child be able to remain in a home setting and that a family member be willing to work with the therapist. The therapist is available to the family 24 hours a day, 7 days a week. An episode of treatment provides approximately 60 hours of contact and lasts from 3 to 5 months. It is thus more intensive than FFT or traditional therapy because it provides several hours of treatment per week or sometimes even daily treatment. Providers are licensed by MST, Inc. in South Carolina which provides a training, support, and quality assurance system aimed at achieving targeted outcomes through treatment fidelity. Recommended costs for the program are \$8,000-\$9,000 per youth while the reported costs in Maryland range from \$5,000 to \$8,000 per youth.²⁴

MST has been evaluated in multiple, well-designed clinical trials that date back to studies published in 1986. Studies show that participation in MST can have significant positive effects on behavior problems, family relations, and self-reported offenses immediately after treatment. Over a year after referral, seriously delinquent youth who participated in MST also had slightly over half the number of arrests as controls, spent an average of 73 fewer days incarcerated in justice system facilities, and showed reductions in aggression with peers. Even after 2.4 years, MST youth were half as likely as control youth to have been rearrested.²⁵

Multidimensional Treatment Foster Care (MTFC) was developed in 1983 as an intervention for adolescents with chronic antisocial behavior, emotional disturbance and delinquency in need of out-of-home placement. The child is placed in a specialized foster home, where the parents receive specific training, supervision and support in order to provide the child with clear and consistent limits, close supervision, follow-through on consequences, positive reinforcement for appropriate behavior, a relationship with a mentoring adult and separation from delinquent peers.²⁶ In contrast to regular foster care or even typical treatment foster care, the child is placed as the sole foster child, or at most with one other foster child, in a family setting for a time-limited 6 to 9 month period after which they return to their family (or to a regular foster home). The family to which the child will return participates in weekly family therapy and parent training in preparation

for the child's return home. It is considered the least restrictive form of out-of-home placement for children with serious emotional disturbance.²⁷ Cost per episode is estimated at approximately \$26,000 or \$115 per day.²⁸

The Center for the Study and Prevention of Violence reports that evaluations of MTFC have demonstrated that when youth who had completed MTFC were compared to control group youth, they spent 60% fewer days incarcerated at a 12 month follow-up, had significantly fewer subsequent arrests, and had significantly less hard drug use.²⁹

The Recent Growth of These Evidence-Based Practices

“The gap between routine mental health care practice and evidence-based practice represents a significant public health problem.”³⁰ It has been widely acknowledged that few individuals who could benefit from EBPs actually receive them but recent progress has been made by many states. Every state reporting on its implementation of EBPs to the National Association of State Mental Health Program Directors Research Institute is providing one EBP and many states now provide at least one of the EBPs that are the subject of this report.³¹ Maryland is no exception with its current initiatives on three adult EBPs and its provision of MST and FFT through grant funding from the Governor's Office on Crime Control & Prevention, DJS funding, and other funding sources. Unfortunately MST and FFT have been provided only in a small number of Maryland's jurisdictions to few children under time-limited funding sources without any long term funding strategy. While treatment foster care is available in Maryland, it is not the Multidimensional Treatment Foster Care that has been identified as an EBP, and typically is only provided to children already committed to DJS, or children in the care or custody of a local Department of Social Services.

MST, FFT, and MTFC are not currently available under Medicaid to children in Maryland's Public Mental Health System operated by the Mental Hygiene Administration. The need to include EBPs in Medicaid covered benefits has been recognized. On a national level, the Subcommittee on Evidence-Based Practices of the President's New Freedom Commission on Mental Health in April 2005 recommended inclusion of EBPs in Medicaid covered benefits.³² On a local level, in October 2006, Dr. Joshua Sharfstein, Commissioner of the Baltimore City Health Department and Dr. Pierre Vigilance, Health Officer for Baltimore County, called upon the Maryland Medical Assistance Program, to add MST to the State Medicaid Plan and to consider adding other EBPs, such as FFT, as well.³³

As recently as February 2003, the Medicaid Subcommittee of the President's New Freedom Commission noted that “few States have taken full advantage of Medicaid financing opportunities to implement these best practices.”³⁴ However, our research indicates that this is rapidly changing as many states have begun using Medicaid funds to cover MST and FST and others are planning to do so. Even more states, including Maryland, cover treatment foster care in their Medicaid State Plans but this service is not typically the same as the EBP of MTFC. As of 2004, the website of the National Association of State Mental Health Program Directors Research Institute listed twelve

states as providing MST under Medicaid.³⁵ Our research indicates that as of now, sixteen states plus the District of Columbia are covering MST with Medicaid funds and an additional two states are planning to do so.

Maryland is falling behind other states in its implementation and maximization of these children's EBPs. The Public Mental Health System and Juvenile Justice System, as documented in the next section, primarily provide other mental health services to delinquent youth with mental illness, services that do not approximate in intensity or effectiveness the three EBPs recommended in this report.

Services Available to Delinquent Youth in Maryland with Mental Illness

The Mental Hygiene Administration (MHA)

It is impossible to pinpoint the number of delinquent youth or at risk youth who now receive mental health services from MHA's Public Mental Health System or the type and frequency of the services they receive. MHA does not separately track services for this segment of the population it serves with Medicaid dollars. However, by looking at the types and number of services provided to children in general, we know that delinquent youth in Maryland are not receiving the type of intensive, home-based or frequent services that come close to what they could receive if FFT, MST and MTFC were available to them.

Since Maryland's MHA began operating its Public Mental Health System with Medicaid funding in 1997 as a fee-for-service carve-out from Medicaid managed care, the number of children served each year has almost doubled.³⁶ Yet national studies indicate that the *majority* of children who are likely to benefit from mental health treatment do not receive *any care*.³⁷ African-American and Hispanic children are even less likely than white children to receive the mental health care they need.³⁸

Maryland children involved with DJS also are not likely to have received the mental health care they needed in the community. While studies indicate that up to 70% of these children may have a diagnosable mental illness, many have undiagnosed mental health disorders and have not been in the public system receiving services.³⁹

Intensive Community-Based Services Are Not Widely Available

Even for children with mental illness diagnoses being served in the public system, data indicates that they do not receive intensive community-based services of the type that could prevent an out-of-home placement or entry into the juvenile justice system. Ninety percent (90%) of the system's current resources are spent either on costly institutional care or on traditional outpatient therapy and medication management services provided in an office on a weekly, biweekly, or monthly basis. By comparison, very few dollars are spent on the type of intensive outpatient services that experts say are necessary to care for a child with serious emotional disturbance at home.

The possibility for regular or frequent in-school, after-school and in-home rehabilitative care that was available through Psychiatric Rehabilitation Programs was eliminated when MHA imposed a monthly reimbursement rate and made other changes in 2004 and early 2005 to respond to budget cut-backs. Service frequency plummeted and has not increased.⁴⁰ Psychiatric Rehabilitation was one of the few MHA community-based services that, like FFT, MST, and MTFC, are provided to children in their natural settings rather than in an office, and the only service in such a natural setting that was widely available.

Approximately half of all Medicaid expenditures reported by MHA for children and young adults through age 21 in FY 2005 and FY 2006 were on inpatient hospitalization and residential treatment center care for between 8% and 9% of the system's users.⁴¹ While there has been a shift nationally as well as in Maryland toward outpatient care, Maryland's reliance on institutional care for children is higher than national estimates (50% of expenditures in Maryland vs. 33% of expenditures nationally).⁴²

The federal Center for Mental Health Services estimates that 10-12% of youth in Maryland have a serious emotional disturbance and 6-8% have an extreme psychiatric impairment.⁴³ These percentages are undoubtedly even higher among the poorer children in Maryland's Medicaid population.⁴⁴

While 98% of all children served by the Public Mental Health System received traditional outpatient services, that averaged 21 visits per year, such bi-weekly office-based services are not likely to meet the needs of delinquent children or children with extreme psychiatric impairment, who are at risk for out-of-home placement.⁴⁵ The public system also has an intensive outpatient treatment option, but in FY 2006 only 332 children or less than 1/10 of 1% of all children in the State on Medicaid received this service.⁴⁶ This is far lower than the estimated 6-8% of Maryland children with an "extreme psychiatric impairment," a percentage that does not even include delinquent youth with behavioral disorders who may fall outside the "extreme psychiatric impairment" category but need more intensive treatment.

Far fewer Maryland children than the number likely to need them receive the other intensive community-based services now covered by the Medicaid Program. The Court in *Rosie D. v. Romney*, 410 F.Supp.2d 18 (D. Mass. 2006), based on extensive expert testimony, found that two of the most essential services for families trying to manage a child with such impairments at home are case management services and in-home behavioral support services. But Maryland's Medicaid Program provided in-home behavioral services to only 1/10 of 1% of the children in the State on Medical Assistance in FY 2006 and targeted mental health case management to only 2/10 of 1% of such children.⁴⁷

An October 2003 report on Maryland by the American Bar Association Juvenile Justice Center repeatedly pointed to the inadequacy of Maryland's community mental health care, including the lack of a continuum of care and the absence of intensive outpatient services, as a reason Maryland children enter its juvenile justice system.⁴⁸

Thus, there is no evidence that DJS-involved youth living in or returning to the community are able to access the type of home-based, frequent, and more intensive services from the Public Mental Health System under Medicaid that might prevent an out-of-home placement or assist in their return home. DJS and MHA have not reported any focused effort to ensure that this population receives intensive mental health services such as in-home behavioral supports, case management, and intensive outpatient treatment despite their high risk for re-arrest, out-of-home placement, and high cost to the State. For DJS youth, the Public Mental Health System simply has offered no equivalent to the treatment provided by FFT, MST and MTFC.⁴⁹

The Department of Juvenile Services (DJS)

Once delinquent youth with mental illness are removed from the community and placed in a residential setting by DJS, the State pays far more for the services the youth receive than they pay for community-based services. Federal law prohibits the state from making use of Medicaid funds to provide delinquent youth placed in secure or locked residential settings with any mental health care or any other healthcare services.⁵⁰ Thus, the State must foot the entire bill for the psychiatric care that up to 70% of the children in these already expensive residential placements will need. As reflected by the Department of Justice's recent investigations and findings, DJS has failed to provide necessary mental health services to children in its detention centers. While DJS does provide funding for some community services and has begun to fund some FFT and MST services for small numbers of children in limited parts of the state, most of the DJS resources, as well as the MHA resources spent on this population, are spent on costly and ineffective residential placements rather than on any community programs like FFT, MST or MTFC with a proven track record.⁵¹

It is critical that Maryland take action to cover these EBPs given the staggering caseload that DJS faces – a caseload comprised largely of children with a diagnosable mental illness who now rarely receive services that will substantially reduce repeated arrests and referrals to DJS. Each year DJS receives over 50,000 referrals.⁵² Up to 70% of these referrals will concern a child with a mental illness and approximately 94% will be for a non-violent crime concerning property.⁵³ Of these referrals approximately 42% (21,000) are formally processed each year.⁵⁴ Of those processed, twelve percent (2,520) of these youth are committed to DJS while twenty-five percent (5,250) are placed on probation annually.⁵⁵ In contrast, despite their proven effectiveness in stemming the tide of continuing criminal activity, only 234 children in Maryland received the cost effective evidence-based practices that are the subject of this report in FY 2006.⁵⁶

The number of children with mental illness in the DJS system is not surprising given the growing national concern about the criminalization of youth with mental illness. Several studies have indicated that families frequently file criminal charges to place their child in the juvenile justice system in order to access mental health services.⁵⁷

Most youth involved with Maryland's DJS are believed to be eligible for Medical Assistance in the community.⁵⁸ Thus, the State could be using Medicaid dollars to bring these EBPs to a significant number of children who enter the DJS system. The Department of Legislative Services (DLS) has noted that DJS is extremely dependent on State general fund dollars and should diversify its funding stream and maximize its attainment of federal funds.⁵⁹ DJS could achieve this by cooperating with DHMH to pursue Medicaid funding to cover EBPs. Appropriate youth referred to DJS that meet the eligibility criteria for FFT, MST or MTFC could be provided with a service that has been demonstrated to reduce the likelihood of further criminal activity, re-arrest and out-of-home placement. Instead, charges for these youth now are likely to be dropped, and if the youth are re-arrested, as is likely, and eventually enter the DJS system, they are more likely to be placed in ineffective residential care than to receive one of the three EBPs that have been proven to work.

A System Focused on Ineffective and Costly Residential Placement

In FY 2007, DJS had an operating budget of approximately \$231,728,000.⁶⁰ Of its budget, DJS spends twice as much on residential placements for youth as it spends on community based services such as detention alternatives and diversion programs. For example, in FY 2006 DJS spent \$104.7 million on residential care versus \$49.1 million on community care.⁶¹ Despite the recognition that juvenile justice systems need to invest more funds into community-based diversion efforts and reduce their reliance on detention, DJS's funding pattern has not changed over time. Proposed DJS spending on "detention and deep-end residential placements" was almost 60% of the department's budget in FY 2005, approximately the same as it was in FY 1998.⁶²

On an average day in FY 2005, the State of Maryland was paying the bill for 1,747 children committed to DJS to be housed in residential programs.⁶³ The average daily costs of DJS residential placements in FY 2004 ranged from \$166 per day for secure committed settings to \$243 per day for detention.⁶⁴ On an annual basis these costs ranged from over \$60,000 per year to over \$88,000 per year. These numbers are likely higher now and do not include the cost of additional psychiatric and health care services that the State must pay for when children are in detention or other secure settings and do not qualify for Medicaid reimbursement.

DJS is not responsible for the cost of care for the children it places in psychiatric residential treatment centers (RTCs). MHA pays the state share of the cost for this covered Medicaid service. Data collected for the Governor's Office for Children Youth and Families has consistently shown that over 40% of the children placed annually in Maryland's in-state RTCs are committed to DJS and placed under court order.⁶⁵ In fiscal year 2002, the average monthly cost of a Maryland RTC was \$17,690 (or \$212,280 annually).⁶⁶ Since MHA spent over \$64 million for RTC care in FY 2005, one can estimate that approximately \$25.6 million was spent on DJS youth.⁶⁷ This is on top of the \$111.7 million dollars that DJS spent on residential care that year.⁶⁸

In contrast, it currently costs only \$5,000-\$8,000 to provide a child in Maryland with MST and only \$2,000 to provide FFT in Maryland.⁶⁹ For children in need of out-of-home placement, MTFC could be provided for \$26,000 per child. As discussed above, these services have been proven to reduce re-arrest rates and out-of-home placement rates.

Given the much higher costs for the residential settings Maryland now uses to serve DJS youth, one would expect that these services would produce better outcomes than the far less expensive EBPs. However, the opposite is true. The legislatively mandated December 2004 Gap Analysis Report prepared for DJS by outside contractors was designed to develop an ideal juvenile justice delivery system for Maryland. As this report points out, “the ultimate long-term indicator of a juvenile justice system’s success is whether the life-course of a delinquent youth is positively influenced in such a way as to prevent future involvement in delinquent and criminal behavior.”⁷⁰ When measured by its recidivism rates, it is clear that Maryland’s juvenile justice system has not been successful by placing children in these residential settings. The Maryland Department of Legislative Services 2006 Analysis of the FY 2007 Executive Budget reflects that 66% of youth released from residential placements are re-arrested within two years and 76% are re-arrested within three years.⁷¹

The Gap Analysis Report identified five critical recommendations out of the forty-two recommendations it made. In two of the five critical recommendations, the report urged DJS to expand its community-based diversion programs and its community-based nonresidential services.⁷² The report specifically listed both MST and MTFC in its survey of nationally recognized best practices.⁷³

The Failure to Provide Appropriate Mental Health Services in Detention Centers

DJS has depended on MHA as it attempts to meet the intense mental health needs of the children it serves largely with state dollars. In addition to MHA funds paying for DJS children in approximately 40% of the in-state residential treatment center beds, in FY 2006 MHA used approximately \$869,866 of its annual federal block grant funds to provide mental health services to children in the DJS system, primarily to provide psychiatric services in detention centers.⁷⁴

Despite DJS and MHA spending on these settings, the United States Department of Justice has made repeated findings under the Constitution and the Civil Rights of Institutionalized Persons Act (CRIPA) that the conditions in several of the DJS facilities are illegal, in part because the psychiatric care is inadequate.⁷⁵ In 2004 and again in 2006, the Department of Justice issued findings letters concluding that conditions violated federal law in Cheltenham Youth Facility (2004), Hickey School (2004), and the relatively new Baltimore Juvenile Justice Center (2006). Many of these findings focused on the DJS failure to provide adequate mental health assessments and treatment for the children in these facilities. Thus, while the vast majority of children in Maryland’s juvenile justice system have a mental health disorder, many have not been able to get adequate mental health services in DJS detention centers. These Department of Justice

investigations have pressured DJS to expend large sums of money in making improvements at these facilities and other detention centers that have failed Maryland's youth rather than in expanding community-based services, such as EBPs that have positive outcome data to support their effectiveness.

Disproportionate Impact on Minority Youth

Finally, the need for Maryland to take action to bring more effective mental health treatment through these three EBPs to children in the juvenile justice system should be of great concern in the State's effort to ensure it provides appropriate and equivalent healthcare services to minority youth. Maryland's failure to make better use of EBPs has a disproportionate impact on minority youth because they make up a larger share of children in the DJS system and children placed in DJS residential settings than they do of children in the general Maryland population. DJS has reported data for 2003 and 2004 reflecting a worsening trend in the overrepresentation of minority populations in secure detention, the committed populations and in the formal caseload.⁷⁶ Thus, the expansion of EBPs in Maryland will be of particular importance in improving the mental health and well being of minority youth.

However, the State must guard against making these EBPs more available to white youth than to minority youth as it has done with other treatment programs in the juvenile justice system. Advocates for Children and Youth reports that when white youth are adjudicated delinquent they are disproportionately referred to "treatment programs" by DJS and the courts. Children of color are more often viewed as having socio-behavioral problems brought on by "lack of supervision" and "a subculture of poverty and violence," and are disproportionately sent to DJS facilities for detention, secure placement, and "correction."⁷⁷ In any effort to expand EBPs, Maryland must guard against perpetuating this differential treatment by acknowledging this problem and taking deliberate action to track and prevent racial disparities in the number of children receiving EBPs.

Value of Keeping Children in the Community

This report focuses on the wisdom of providing these community-based EBPs because they lead to more positive outcomes for children and also reduce state spending. However, there are many other reasons that such community-based care is favored for children with mental illness.

In 1999, the United States Supreme Court issued the landmark decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), that supports the right of people with disabilities receiving state services to live in the most integrated setting appropriate to their needs, where they can participate in the mainstream of society and community life. The Court found that unjustified isolation of persons with disabilities in segregated institutions by the State is a form of discrimination based on disability. The use of these EBPs would be instrumental in enabling Maryland's juvenile justice system to reduce its segregation of delinquent youth so they can participate fully in family life and society alongside their non-delinquent peers.

Another critical reason for keeping children in the community is to increase parental participation in their treatment and in their lives. Children's mental health System of Care values emphasize that services should be family-focused with families as full participants in all aspects of planning and delivery.⁷⁸ One of the distinguishing features of these EBPs is their focus on engagement of the family. When DJS removes children from their home and places them in out-of-home settings, such family involvement in treatment is dramatically reduced.

Denial of educational services is also a problem when delinquent children are removed from their home and community. All children in the DJS system have a right to receive an education and many children have a mental illness or other disabilities that means they have special education needs. The United States Department of Justice found that Maryland children placed in the above-referenced detention centers were deprived of special education services and resources.⁷⁹ But whenever a student committed to DJS is placed in any out-of-home setting, that student is at a greater risk of experiencing gaps in educational services. Due to the location of the placement, the student will most likely be required to transfer to a different school and possibly in a different county. These transfers can lead to gaps in educational services either due to enrollment barriers, problems getting school records, and challenges in having the services from an Individualized Education Plan (IEP) from another county implemented.⁸⁰ Moreover, parents are less able to participate in their child's education if he or she is placed out-of-home. FFT and MST will enable more children to remain in their current home settings and thus prevent the disruption in education services that children in the DJS system now experience.

Thus, in taking action to make these three EBPs available to as many children as possible, the State will be promoting *Olmstead* integration of children with disabilities, engaging families in their child's treatment, and increasing the likelihood that delinquent youth will receive appropriate education services.

The Availability of Evidence-Based Practices in Maryland Compared to Other States

Status of Current EBP Programs Operating in Maryland

Multisystemic Therapy (MST)

Of the two EBPs proven effective with delinquent youth that have been provided on a small scale in Maryland, the State has had more experience with MST. Currently there are four counties in Maryland where MST is being planned or provided: Baltimore City, Baltimore County, Frederick County, and Prince George's County. All four consist of a single MST team and are time limited, grant funded programs. Anne Arundel County also operated an MST program but it lasted only two years due to lack of continued funding.

The oldest and largest of the existing MST programs has been operated by the Baltimore County Bureau of Mental Health, a Core Service Agency, under a five-year grant for approximately \$300,000 each year from the Governor's Office of Crime Control and Prevention.⁸¹ Services are delivered by a provider named Psychotherapeutic Treatment Service Inc. that is certified by MST Services, Inc, the national center for MST. Under the program, therapists with small caseloads receive training in MST and go into the home and other settings 24/7 to work with a parent or primary caregiver and a child of 11 to 17 years of age intensively for an average of 5 months with the goal of reducing criminal or other antisocial behaviors. Master's level therapists deliver the services with a low caseload of 4 to 6 families and receive intensive supervision from a program supervisor and a consultant from MST Services, Inc. The Baltimore County program has served up to 52 Baltimore County youth annually for the past 4 ½ years under its grant. Since its second year of operation there has been a waiting list. The two largest referral sources for the program have been DJS and the school system with other referrals coming from many sources such as the police, the Public Defender, substance abuse agencies and providers, the courts, and mental health agencies and providers.

The cost per youth for Baltimore County's MST Program has been between \$6,000 and \$7,000. However, MST Services Inc. recommends a cost per youth of \$8,000-\$9,000 in order to maintain higher salaries and thus better retain staff. Although approximately 43% of the service recipients have been on Medicaid, the program has not billed Medicaid for these services, paying for the program entirely with state grant funding.

Baltimore County's outcomes for its MST program have been positive. They contracted with the University of Maryland, Baltimore County to measure the quality and outcomes of the program both while it is ongoing and after the programs ends. The Baltimore County Annual Research Report for FY 2005 indicates that following MST treatment, youth reported statistically significant decreases in several important MST targets: use of alcohol and other drugs; number of person offenses (e.g. assault) committed; and time spent associating with delinquent peers. In addition, MST treatment completers showed 64.4% fewer arrests for all types of offenses following treatment than they did prior to treatment.⁸² In Appendix B, we include the story of a successful MST participant who had been arrested twice, abused alcohol and marijuana, and failed to attend school before entering the program.⁸³

In addition to these outcomes, another compelling thing about the program is that when children complete it, they do not require linkage with an array of ongoing Public Mental Health System services funded by Medicaid. Many of these children were not previously seen in the mental health arena and the goal is that they will not need other mental health services at the end of the program, or if they do, it will likely be only an outpatient therapist.

Despite this success, the grant will end in June 2007 and the County is trying to find other funding sources including private funding to continue the program beyond that date.⁸⁴ But even if they are successful, this would still yield a time-limited, grant funded approach to service delivery for a limited number of youth.

In FY 2006, the Baltimore County Health Department began collaborating with the Baltimore City Health Department's Operation Safe Kids to pilot a MST program in the City. The MST provider was also Psychotherapeutic Treatment Service Inc. Baltimore City provided the funding for this program. Due to start-up problems, such as delays in hiring therapists and problems with referrals, the program was able to serve only 11 children rather than the planned 35 youth. The Baltimore City Health Department is now planning a new MST program for the City which will be administered by Baltimore Mental Health Systems, the Core Service Agency, and will serve between 50 and 60 families a year or 16 to 20 youth at one time. The program is funded for two years primarily with a federal grant from the Department of Justice but also with some City funds. Although Medicaid is not being billed for the past or planned MST services in the City, it is estimated that close to 100% of the children served would be eligible.⁸⁵

In Prince Georges County, the MST program began in April 2004 with a grant of \$226,000 from The Governor's Office of Crime Control & Prevention that has enabled it to serve a total of 130 children since its inception. The provider, Community Counseling and Mentoring Services Inc., can serve 15 children at one time when operating at capacity, or approximately 45 children per year. The Department of Juvenile Services has picked up the funding for this program starting in 2007 for one year, committing \$100,000, but has not made a longer commitment to fund the program.⁸⁶ Currently the majority of children (85%) are referred from DJS with the remaining referrals from the Department of Social Services, schools and community mental health centers. However, as of 2007 all referrals are made by DJS. The current cost per youth per episode of care is approximately \$5,000.⁸⁷

In Frederick County, state funds of \$130,000 per year through the Governor's Office of Crime Control & Prevention since 2003 support a small MST program by a provider named Way Station, Inc. They served 52 children in three years and are able to serve only 20 children a year. They report that this funding is not sufficient to cover all program costs.⁸⁸

The Anne Arundel County Juvenile Drug Court operated an MST program with funding from the U.S. Department of Justice from 2002 to 2004 that served approximately 25 youth but closed due to lack of funding.⁸⁹

Functional Family Therapy (FFT)

In contrast to MST, there are only two FFT programs in the State, one in Baltimore City and one serving youth in Calvert, Charles and St. Mary's Counties. The Southern Maryland Program began in 2002 and the Baltimore City Program began in 2006. Although there are just two programs, they are planning to serve more youth in one year than Maryland's MST programs have served over the past 5 years. This is presumably due to the significantly lower cost of FFT that is designed to serve children with less intensive needs.

The Local Management Board, The Baltimore City Family League, oversees three FFT teams. Funding for one team, which began in April, 2006, is through the Governor's Office of Crime Control & Prevention. The other teams started in August 2006 and are funded for FY 2007 with \$700,000 from the Department of Juvenile Services. Again, DJS has not made any commitment to continue this funding beyond one year. When all three teams are operating at capacity, it is estimated that 450 Baltimore City children may be served in the year but in FY 2006 the program served only 48 children. There are two providers delivering FFT services, Building Communities Today for Tomorrow and Progressive Life. Although the recommended eligibility criteria for FFT are even broader than those for MST and include youth at risk for delinquent and acting out behaviors, DJS has narrowly defined the eligibility to children under DJS supervision at risk of out-of-home placement. Thus, both the size limitation on the program and the more restrictive eligibility criteria will prevent many Baltimore youth who could benefit from FFT from receiving this service.

The cost per youth per episode of service (with an average length of three months) is \$2,000. Maryland is again not billing Medicaid for any of its FFT services although it is estimated that 85-90% of Baltimore City's youth receiving the service are on Medicaid.⁹⁰

The only other FFT program in the State served youth in Charles and St. Mary's Counties and just has started serving Calvert County youth as well. The Program began in 2002 and has been funded with Family Preservation funds that may end in June 2007 and a grant from the Governor's Office of Crime Control & Prevention that will end in June 2007. They have struggled to maintain enough funds to keep it going and have suffered funding losses. The program expects to receive \$100,000 from DJS in 2007. The provider is the Center for Children. Since the inception of the program, they have treated 108 children. The cost per youth per episode is slightly above \$2,000, the higher cost due to the rural area necessitating travel. Maryland bills no part of this FFT program to Medicaid and thus the future of the program is in constant jeopardy as alternative sources of funding are continually being sought.⁹¹

Multidimensional Treatment Foster Care (MTFC)

While treatment foster care already exists in Maryland and is covered by the Medicaid State Plan, it is not the same service as the EBP of Multidimensional Treatment Foster Care (MTFC). On August 31, 2004, the Center for Medicare and Medicaid Services approved DHMH's submission of State Plan Amendment (SPA) Transmittal Number 04-19, permitting Maryland to add residential rehabilitation services for persons less than 21 years of age to its Medicaid State Plan.⁹² The SPA states that residential rehabilitation includes placement in treatment foster homes and residential group homes for persons under 21.

But a recent study of treatment foster care services in Maryland documents that the model of treatment foster care being implemented is not the same as the EBP of MTFC. According to *Maryland Science to Service for Children's Mental Health, A Study of Treatment Foster Care in Maryland*, prepared in September 2005, Maryland's treatment

foster care does not include characteristics of the evidence-based MTFC model that has been shown to produce positive outcomes for youth.⁹³ According to this study, Maryland's programs are serving a much more diverse group of youth for a much longer period of time than intended under the model. It also noted that these programs would require more resources to implement the model in order to cover, for example, higher stipends for treatment parents, intensive training of treatment foster parents, daily phone contact from program staff, 24/7 access to program staff, program support to implement a behavior plan, and planned respite on a regular basis. Thus, Maryland cannot now achieve the same positive outcomes for youth in treatment foster care as under MTFC, the evidence-based practice.

Maryland needs to develop a MTFC component for its existing treatment foster care service that is already billed under Medicaid. This does not mean that the State should not continue to provide treatment foster care outside the MTFC model.⁹⁴

As documented above, the State now has a small number of successfully operating MST and FFT Programs with managers, providers and therapists who have developed an expertise in delivering these EBPs. Although Maryland does not have a certified MTFC program, it has a large network of treatment foster care providers that undoubtedly would be interested in developing a MTFC component to their programs. If Maryland covers these services with Medicaid dollars and builds statewide MST, FFT and MTFC programs, it will not have to start from scratch but can draw on the knowledge that these individuals and organizations, who have been delivering these services in Maryland, already possess. But if Maryland continues with its current piecemeal approach to funding of these services, there is a danger of losing the expertise of these MST and FFT program professionals as programs lose funding and close, and it will be much harder to reestablish these EBPs in the future.

Status of EBP Coverage by Other State Medicaid Programs

The situation with respect to Medicaid coverage of EBPs is changing rapidly as many states have only recently begun using Medicaid funds to cover MST and FFT and others are planning to do so. While just a few years ago states were uncertain about how to cover EBPs under Medicaid, MDLC has documented that currently sixteen states plus the District of Columbia are billing Medicaid for MST services and two additional states are planning to do so.⁹⁵ With respect to FFT, we have documented that five States are billing Medicaid for these services.⁹⁶ It is likely that more states than could be identified are covering these EBPs with Medicaid because many states bill for these services under broad service and billing categories already in State Medicaid Plans, such as rehabilitation services or in-home intervention services, rather than by the name of the EBP.

This growth in Medicaid billing for these EBPs is not surprising given the support for Medicaid coverage of EBPs coming from The Substance Abuse and Mental Health Services Administration (SAMHSA), The Center for Medicare and Medicaid Services (CMS), and the President's New Freedom Commission on Mental Health; the practical

need to use Medicaid dollars in order to bring EBPs to a significant number of children who need them; and the legal dictate that all medically necessary health care services be provided to youth under 21 covered by Medicaid.⁹⁷ Maryland can learn and benefit from the work these States have done to develop clear service descriptions, eligibility criteria, and billing practices that have already been approved by CMS.

Medicaid Billing Practices

One of the primary concerns about coverage of MST and FFT under Medicaid is that some of the service costs, such as training and evaluation components, can be significant but are not billable to Medicaid. Based on the experience of other states, this obstacle can be overcome when the Medicaid agency and the other agencies serving children work together to identify the state dollars that must be available to cover these costs as well as the state match for the services. These additional state dollars should be viewed as a safe investment that is guaranteed to yield a higher return given the documented cost savings generated by these practices that are discussed throughout this report and detailed below. In other states, private grants, federal funds, state funds or a combination of these sources, have covered the cost of the non-Medicaid aspects of treatment. Funding at the state level frequently comes from the state juvenile justice agency as the entity that stands to benefit the most from cost savings associated with the provision of these evidenced-based practices. For example, in Michigan, state funds to support MST come from Michigan's Department of Juvenile Justice and Department of Human Services. In Connecticut, which previously covered MST under Medicaid and is again planning to do so, funds come from the Judicial Branch Court Support Services Division and the Department of Children and Families.⁹⁸

Another concern is ensuring a method of billing these practices that is not burdensome for providers but ensures that only the components covered by Medicaid are being billed. Medicaid services are billed to the Center for Medicare and Medicaid Services (CMS) using the Healthcare Common Procedure Coding System (HCPCS). In 2003, CMS created a HCPCS code – H2033 -- just for states to bill MST in 15-minute increments. CMS has approved a state plan amendment submitted by North Carolina to add MST as a covered service.⁹⁹ North Carolina and New Mexico bill Medicaid using the H2033 HCPCS code.¹⁰⁰

However, other States bill MST under other broader billing codes and incorporate MST as part of other existing services in their Medicaid State Plans. For example, Pennsylvania bills MST under 'Integrated Children's Services,' Nebraska under 'Intensive Outpatient Program for Antisocial Youth,' Maine under 'In-Home Treatment Service,' Texas under 'Rehabilitative Services for Children,' California under 'Outpatient Mental Health Services,' and D.C. under 'Community Based Intervention.'¹⁰¹

Other states, such as Arizona and Nebraska, provide MST services through Managed Care Organizations (MCOs) with capitated rates. In these states, MST providers bill the MCO for the service and the MCO generally pays the provider a per diem rate.

FFT has been implemented in more than 20 states as well as internationally.¹⁰² We have documented that at least five of these states, California, Maine, New Mexico, New York, and Pennsylvania, bill Medicaid for the service. At this point, there is no Medicaid billing code for FFT so states bill under existing codes. For example, Pennsylvania bills FFT under ‘other rehabilitation services’ and in California under a combination of ‘family therapy,’ ‘collateral contact,’ and ‘case management.’¹⁰³

The Importance of Model Fidelity

Another concern in covering these practices under Medicaid has been whether the state will implement the practice with strict adherence to the original EBP model, known as “model fidelity.” This is critical because one of the primary reasons these programs are effective when replicated is that they are *standardized* and each new program adheres to the same model. Even subtle changes will have a negative impact on a program’s outcomes.¹⁰⁴ The standardized components of these EBPs, such as training, use of certified providers, intensive supervision, ongoing consultation, ongoing evaluation, and data collection for outcome studies are the defining characteristics of these practices and adherence to them must be non-negotiable. Yet there could be a temptation for states to try to cut corners on these components because they are not Medicaid billable. To safeguard against this, when adding MST and FFT to the State Medicaid Plan, Maryland should continue to require providers to be approved or certified by the national centers for each of these practices in order to ensure that model fidelity is not compromised.

States now billing Medicaid have required that all EBP providers be approved or certified by the appropriate EBP national center in order to qualify to deliver these services. Such requirements do not conflict with federal law that states must permit any willing *and qualified* provider to deliver Medicaid services.¹⁰⁵ The only providers actually delivering these EBPs and, who are qualified to do so, are those approved or certified by MST Services, Inc. in South Carolina, FFT, LLC in Seattle, Washington, and TFC Consultants, Inc. or The Center for Research to Practice in Oregon. If other providers were to seek to deliver these EBPs without approval or certification, they would not be qualified because they would not be participating in the standardized treatment program and delivering the actual EBP.¹⁰⁶

Billing for Treatment Foster Care is Widespread

With respect to treatment foster care, many states are covering this service under their Medicaid Program.¹⁰⁷ In *Katie A. v. Bonta*, 433 F.Supp.2d 1065, 1076 n.14 (C.D. Ca. 2006), the Court found that twenty states were covering treatment foster care under their Medicaid Programs and ruled that California must include treatment foster care as a service in its Medicaid Program. It is likely that even more states are covering treatment foster care services as “residential rehabilitation services,” as Maryland does, or under other service categories, and were therefore not included in the Court’s count. Most of these states are covering treatment foster care but have not developed a *Multidimensional* Treatment Foster Care component to their program, as is the case in Maryland.¹⁰⁸

However, Medicaid is being billed for MTFC by states providing it according to TFC Consultants, Inc. in Oregon. This program provides “implementation” services to MTFC programs that will then seek certification as MTFC providers through another organization, The Center for Research to Practice. They report that although there is no separate Medicaid billing code for MTFC yet, states are billing MTFC to Medicaid. Their website documents the current certified sites as well as the programs where MTFC is being implemented.¹⁰⁹ Since treatment foster care is already included in Maryland’s Medicaid State Plan, the State and treatment foster care providers should work with TFC, Consultants, Inc. to develop a MTFC component to the program.

There is no reason that Maryland should not move forward, as other states have done, to cover FFT, MST, and MTFC with Medicaid dollars because, as documented in the next section of the report, these three EBPs have been proven to reduce state spending while having positive outcomes for children and their families.

Cost Effectiveness of Evidence-Based Practices

Despite the reported deficit – or because of it – the State should invest in these EBPs by billing them under Medicaid. DHMH should not be deterred by a fear that EBPs amount to new entitlements that could open the floodgates and lead to potentially higher spending. As numerous studies have shown, these practices are focused on a population of delinquent youth that are currently costing the State huge sums of money, money that is being spent unwisely on costly residential placements that do not substantially reduce re-arrest rates or help most youth and their families. Many studies, reports and experts have documented cost savings that stem from positive outcomes for these EBPs. The National Center for Mental Health and Juvenile Justice summarized these findings as:

- Reduced long-term rates of re-arrest,
- Improved family functioning and school performance,
- Decreased substance abuse and psychiatric symptoms,
- Reduced rates of out-of-home placement, and
- Significant cost savings.¹¹⁰

There is simply no other community-based mental health service currently provided in the State of Maryland - not even wrap-around - that can boast such outcomes documented by scientific study. Maryland cannot afford to wait any longer before widely making these practices available to its youth.

The definitive analysis of the relative cost effectiveness of juvenile justice treatment programs was first published by The Washington State Public Policy Group in 1998 and updated by its 2001 publication, *The Comparative Costs and Benefits of Programs to Reduce Crime*.¹¹¹ Of the fourteen programs studied, MST, FFT, and TFC ranked highest in cost savings given the findings that:

- MST saved taxpayers approximately \$31,661 in subsequent criminal justice cost savings for *each* program participant. When the benefits to

crime victims were also considered, it increased the expected net present value to \$131,918 per participant, which is equivalent to a benefit to cost ratio of \$28.33 for every dollar spent.

- FFT saved taxpayers approximately \$14,149 in subsequent criminal justice cost savings for *each* program participant. When the benefits to crime victims were also considered, it increased the expected net present value to \$59,067 per participant, which is equivalent to a benefit to cost ratio of \$28.81 for every dollar spent.
- MTFC saved taxpayers \$21,836 in subsequent criminal justice cost savings for *each* program participant. When the benefits to crime victims were also considered, it increased the expected net present value to \$87,622 per participant, which is equivalent to a benefit to cost ratio of \$43.70 for every dollar spent.

The Washington State cost comparisons are remarkable but the savings will be even greater in Maryland if it covers these practices under Medicaid. The computations done in Washington assume that the entire cost of the EBP will be borne by the State. But if Maryland covers these practices under Medicaid, it will receive a 50% federal match. Although there are some costs that cannot be covered by Medicaid, such as the necessary training associated with these practices, Maryland still can expect to reap even greater savings in taxpayer dollars than the Washington State studies concluded.

While the Washington State cost comparisons were computed mathematically using expert analysis, others have explained the cost analysis simply in common sense terms. In an article about MST, the New York Times Magazine interviewed Bart Lubow, director of a program for high-risk children at the Annie E. Casey Foundation in Baltimore, to point out that residential treatment centers and juvenile corrections facilities are not worth the money states spend on them. “‘These programs generate high recidivism rates’ . . . And they can cost at least \$50,000 per child. ‘That would be O.K. if you were getting a reasonable return on your investment,’ . . . ‘But the outcomes are very poor.’”¹¹² To make MST cost effective it is for children at high risk of expensive out-of-home placements. “‘If enough of them can be kept at home, the program can pay for itself --- and even save communities money.’”¹¹³

Not only have these practices been proven cost effective elsewhere, but they have successful track records in Maryland as well. In the most recent data on the Baltimore County MST Program, of the 41 youth served in the program, 93% were still living at home, 87% were successful in school and work, and 87% had no new arrests.¹¹⁴ According to the latest annual report on outcomes from the Prince George’s County MST Program, after receiving MST, 78% of participants were still living at home, 75% were successful in school and work, and 75% had no new arrests.¹¹⁵

Another compelling cost consideration in a decision to cover EBPs under Medicaid is the fact that federal law prohibits youth in locked or secure juvenile facilities from accessing

any healthcare services under Medicaid.¹¹⁶ Thus, in contrast to youth served under EBPs, for youth in secure residential settings, DJS is now paying for an expensive placement *plus* the cost of behavioral and somatic health care services with state only dollars.

The diversion of delinquent youth from placement in a residential treatment or detention center will not immediately lead to cost savings on these placements because Maryland has an established bed capacity for these programs and other children are likely to fill those beds. But the State can expect immediate cost savings in many other areas because DJS has significant costs unrelated to bed capacity but rather tied to the number of cases that it must handle. As juvenile arrests decline, DJS will save money as it handles fewer referrals, fewer children are formally processed, fewer children must be assigned to workers, fewer children are put on community detention or probation, and fewer children are placed in other residential programs such as group homes, foster homes and out-of-state residential treatment centers without an established number of beds. Over time, the vacancy rate for residential treatment and detention beds will increase as the demand for these beds falls, permitting the State to close beds and reduce bed capacity.

The Department of Legislative Services (DLS) has criticized plans to reform DJS by increasing spending on community-based programs, including mental health services, just because the “need is apparent.” They have repeatedly requested but not received independent evaluations that will document outcomes.¹¹⁷ Similarly, DLS and the General Assembly have for years raised concerns that MHA has no outcome data to measure the impact of the State’s significant investment in community mental health services.¹¹⁸ But these independent evaluations and outcome data already exist for the three practices detailed in this report. As the Washington State Institute for Public Policy reasoned, just as a wise homeowner invests in insulation for his home in order to save on future heating bills, Maryland should invest in these three EBPs that have been researched over many years and proven in scientific and real life studies to save states money in their spending on delinquent youth.¹¹⁹ The wisdom of this fiscally sound investment is even more compelling because the future of Maryland’s delinquent and at risk youth depends on it.

State Action to Expand Children’s Evidence-Based Practices in Maryland

MHA and DJS have demonstrated interest in moving forward to expand the use of EBPs for children in Maryland but have not taken the necessary action. If Maryland is to maximize its use of these EBPs and provide access to a significant number of youth, it must cover these services under its Medical Assistance Program as a growing number of other states have done. Since Dr. Sharfstein and Dr. Vigilance called upon state officials months ago to cover MST and other EBPs with Medicaid, state officials have considered the idea and spoken favorably about it but have not taken action or made a commitment to do so.¹²⁰ The required action would be DHMH’s submission of a State Plan Amendment to the Center for Medicare and Medicaid Services to add MST to its State Medicaid Plan and the preparation of a Memorandum of Understanding between DHMH

and the agency or agencies responsible for the state matching funds and the funds to cover the MST components that are not billable to Medicaid.

To its credit, MHA has already implemented three adult EBP projects involving family psycho-education, supported employment and assertive community treatment. It has used Medicaid to fund these services where possible and provided an enhanced rate to providers to encourage provision of the services. With respect to children's EBPs, MHA is planning to fund a children's institute that will focus on the expansion of EBPs. MHA also formed an EBP Subcommittee of the Children's Blueprint Committee. The group is currently meeting monthly to rate about twelve EBPs with the goal of selecting a few for further action. But this Subcommittee is not designed to focus on which EBPs can and should be funded under Medicaid. That authority rests within the Medicaid Division of DHMH.

DJS also has taken concrete steps forward recently by actually funding MST and FFT programs in Maryland with state only dollars. However, their investment is small, limited to three projects for only one year, uses very narrow eligibility criteria that eliminate many children who should be eligible, and future funding is uncertain.¹²¹

Representatives from both agencies spoke favorably to MDLC about the prospect of using Medicaid to cover MST. An MHA official reported that the State has investigated how other states are billing MST in order to see if billing under a case rate was possible but eliminated such a rate as an option due to feedback that the Center for Medicare and Medicaid Services (CMS) is not likely to approve it. Instead, the official said the likely plan would be to bill MST under the existing MST billing code that CMS created. Reportedly, MHA and DJS have discussed DJS paying the state matching funds if MST is added as a Medicaid service. This makes sense since the eligible children are either involved with DJS or likely to become involved in their system. Thus, DJS is the agency that will reduce spending on out-of-home placements and many other costs if MST is available to more children in Maryland. DJS Director of Behavioral Health Services, Dr. Andrea Weisman, has confirmed that DJS is willing to cooperate to the extent it has the funds to do so.

In addition to DJS budgetary limitations, it is also unclear whether, given the DJS limitation on current MST and FFT funding to those under their supervision, it will be willing to pay the state match for MST services for a broader group of youth that is the intended population for these services. When implementing these programs, Maryland should be following the clinical eligibility criteria, that are tied to research on effectiveness, coming from the national centers for these practices, rather than criteria imposed by state agency personnel at DJS.

The General Assembly also has demonstrated interest in and support for evidence-based practices. According to the Department of Legislative Services Analysis of the FY 2007 budget, it was the "intent of the committees that the Mental Hygiene Administration (MHA) maximize the use of evidence-based practices," and MHA was asked to submit a report to the General Assembly related to EBPs including a "time-table for maximizing

the use of EBPs” by November 1, 2006.¹²² This report has not yet been filed, but it is obvious that the State cannot maximize the use of EBPs as other states have done without covering these practices under Medicaid. Moreover, Federal law also requires that they do so.

The Dictates of Federal Medicaid Law

This report has documented that treatment foster care is already included in Maryland’s Medicaid State Plan and many states already are covering MST and FFT under their Medicaid Programs and receiving federal reimbursement. This means that the Center for Medicare and Medicaid Services has determined that these EBPs are health care services that fall within the coverage of the Federal Medicaid Act. By virtue of Medicaid’s Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) mandate, these three EBPs thus are a legal right for children under 21 on Medicaid when a treating professional finds one of them to be medically necessary because a child meets the clinical eligibility criteria for the EBP. The medical necessity of MST and FFT has been widely recognized by many scientific studies and medical professionals including Dr. Joshua Sharfstein and Dr. Pierre Vigilance for children in their jurisdictions. If Maryland’s Medical Assistance Program must cover mental health services for delinquent youth that have not been proven effective, such as residential treatment center care, then certainly the State must cover those mental health services that actually work.¹²³

In 2006, Federal District Courts in Massachusetts and California issued decisions under the EPSDT provision of the federal Medicaid Act, requiring states to expand their Medicaid service array to include therapeutic foster care, wraparound services, comprehensive assessments, case management or service coordination, and in-home behavioral support services. *Rosie D. v. Romney*, 410 F.Supp.2d 18 (D. Mass. 2006) and *Katie A. v. Bonta*, 433 F.Supp.2d 1065 (C.D. Ca. 2006).¹²⁴ Although these decisions did not specifically address the legality of a state’s failure to provide MST and FFT services, they reaffirmed established case law holding that states may not deny *any* medically necessary healthcare service to a person under 21 whether it is in the State Medicaid Plan or not, provided that the service is *capable* of being covered by the Medicaid Act. They also concluded that Medicaid recipients under 21 with serious emotional disturbance have a legal right to receive in-home behavioral services that have been demonstrated to be effective.

In *Rosie D.*, 410 F.Supp.2d at 26, the Court stated:

“The breadth of EPSDT requirements is underscored by the statute’s definition of ‘medical services.’ Section 1396d(a)(13) defines as covered medical services any ‘diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services . . . for the *maximum reduction of physical or mental disability* and restoration of an individual to the best possible functional level.’ . . . Thus if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state’s Medicaid plan pursuant to the EPSDT mandate.”

Similarly in *Katie A.*, 433 F.Supp.2d at 1074, the Court pointed out that “ ‘Congress did not grant or allow states the discretion to define what types of health care and services would be provided to EPSDT children’ As stated in *Rosie D.*, *supra*, ‘the *only* limit placed on the provision of EPSDT services is the requirement that they be ‘medically necessary.’ ” Maryland’s Court of Appeals reached the same conclusion in *Jackson v. Millstone*, 369 Md. 575, 600 (2002).

The fact that Maryland has an array of other mental health services it covers under Medicaid will not excuse it from its legal obligation under EPSDT to “provide all *necessary* services with reasonable promptness.” *Rosie D.*, 410 F.Supp.2d at 34. A “state may not substitute a different service that it deems equivalent.” *Id.* at 26. But, as discussed above, in the case of MST and FFT, the Public Mental Health System currently fails to offer any equivalent mental health service to the population of delinquent youth on Medical Assistance.

With the body of scientific research backing the effectiveness of these three EBPs as opposed to other available services, it is clear that, if they were available, Maryland’s mental health professionals would find them “medically necessary” for patients who meet the clinical eligibility criteria. While clinicians in Maryland do not typically refer their patients now for MST, FFT and MTFC, if these services were added to the billing codes and programs existed, professionals would surely make referrals for them. In those areas where grant funded programs have operated, Maryland professionals have made referrals for FFT and MST. The Baltimore County MST program has even had a waiting list. As the Court in *Rosie D. v. Romney*, 410 F.Supp.2d at 25, pointed out, “it is well understood by anyone familiar with provision of Medicaid services . . . that clinicians hesitate to prescribe treatments and services for Medicaid patients that are not specifically listed in billing codes.”

When DHMH moves forward to cover these EBPs under Medicaid, it should do so by amending the Medicaid State Plan and not by applying for a Medicaid Waiver. A waiver could seek to limit the coverage of these practices to only a few jurisdictions or to a finite number of children statewide. But under EPSDT, all children in Maryland who could benefit from these practices have a legal right to receive them, and thus a limited waiver is not appropriate. The Center for Medicare and Medicaid Services has made it clear that waivers are designed to add services that cannot be covered by a State Medicaid Plan and should not be covering services -- such as FFT, MST and MTFC -- that may be covered by EPSDT under the Medicaid Act.¹²⁵

Thus Maryland is vulnerable to a legal challenge that it currently does not provide FFT, MST and MTFC to the children with mental illness on Medicaid who need these services, although it is under a federal mandate to do so.

Conclusion and Recommendations for Action

Maryland prides itself on having a network of strong mental health services for those youth served by the public sector and spends huge sums of money on these services. Not only DJS and MHA but many other state and local agencies such as the Department of Human Resources, the Governor's Office for Children, the Alcohol and Drug Abuse Administration, the Department of Education, local Departments of Social Services, local Core Service Agencies and Local Management Boards are all part of a massive effort to provide mental health and substance abuse services to youth who are engaged in delinquent, violent, anti-social, and substance abusing behaviors. Yet while agencies at the state and local level spend millions of dollars in an earnest effort to address the problems of delinquent youth, they are not currently using the best tools available -- the cost-effective and highly touted evidence-based practices of Functional Family Therapy, Multisystemic Therapy, and Multidimensional Therapeutic Foster Care.

Maryland has fallen far behind many other states that have expanded their Medicaid programs to cover at least one of these evidence-based children's mental health practices. Through a series of time-limited grants and a patchwork of funding, state and local agencies have attempted to bring these services to a small fraction of the youth who need them. But they are struggling to sustain or expand these programs and have no long term funding strategy to do so. Only a handful of the children who could benefit from these practices now receive them while the State continues to spend huge sums of money on ineffective residential placements. MHA and DJS speak of moving forward to maximize the use of EBPs but have not taken the necessary action. The goal of this report has been to make it clear that from a policy perspective, a cost perspective, and a legal perspective that Maryland cannot afford to wait any longer. It must act now to cover these practices under its Medical Assistance Program.

Recommendation 1: DHMH should act first to cover MST services under Medicaid because this EBP is covered by many states and has its own Center for Medicare and Medicaid (CMS) billing code. DHMH's Medicaid Division and MHA should submit a State Plan Amendment (SPA) to the CMS regional office by June 30, 2007 for approval to cover MST under the State Medicaid Plan. When approved it will permit the current MST programs to bill retroactively to the date the SPA was submitted. Prior to submission, Maryland should review and adapt the state plan amendments and service descriptions for MST from other states, such as North Carolina, that have already been approved by CMS.¹²⁶ If CMS is not willing to grant a per diem case rate for MST, MST should be billed in 15-minute increments using the existing Healthcare Common Procedure Coding System (HCPCS) code for MST.

Recommendation 2: Following approval of the State Plan Amendment (SPA) to cover MST, DHMH's Medicaid Division and MHA should submit a SPA to the Center for Medicare and Medicaid Services by December 31, 2007 for approval to cover FFT under the State Medicaid Plan or make a determination that FFT will be billed as a Medicaid service under an existing billing code as other states have done.

Recommendation 3: Maryland should develop a Multidimensional Treatment Foster Care (MTFC) component of the existing treatment foster care service that is already part of the State Medicaid Plan by December 31, 2007.

Recommendation 4: Following approval by the Center for Medicare and Medicaid Services of the submitted State Plan Amendment to cover MST and, if necessary, FFT, DHMH should immediately draft regulations on MST and FFT.

Recommendation 5: DHMH's Medicaid division should work with MHA, DJS and the other agencies serving children to draft a Memorandum of Understanding that details a cost sharing arrangement to pay the state share of the costs for MST, FFT and MTFC. The state share of the necessary funding should be paid primarily by DJS because it will be the agency to benefit most by the cost savings in reductions in crime and reductions in out-of-home placements.

Recommendation 6: In its development of the above State Plan Amendments and regulations, DHMH should maintain strict model fidelity to these EBPs, such as adopting the requirement that MST providers be licensed by MST Services, Inc. and using the recommended eligibility criteria for these EBPs that do not limit services to children already committed or referred to DJS.

Recommendation 7: If DHMH does not develop and submit a State Plan Amendment (SPA) to CMS to cover MST, does not submit a SPA for FFT or cover FFT under an existing service, or does not add a MTFC component to its treatment foster care program by January 1, 2008, the General Assembly should take action to require DHMH to take these steps and to require DJS and other agencies as appropriate to share in the state portion of the costs for these services.

Endnotes

¹ FY 2006 Budget, Volume III at 626.

² Shufelt, J. & Cocozza, J., *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*, National Center for Mental Health and Juvenile Justice, June 2006; Teplin, L., Abram, K., McClelland, G., Duncan, M. Mericle, A., *Psychiatric Disorders in Youth in Juvenile Detention*, Archives of General Psychiatry, December 2002. An older study of youth in Maryland's system based on data from 1996 found that 25% had immediate needs for treatment and 53% had a diagnosable mental illness. Shelton, D., *Estimates of Emotional Disorder in Detained and Committed Youth in the Maryland Juvenile Justice System (1998)*.

³ Analysis of the FY 2007 Executive Budget, Department of Juvenile Services at 15, ex. 8 (2006).

⁴ Analysis of the FY 2007 Executive Budget, Department of Juvenile Services at 27 (2006).

⁵ While Medicaid coverage is essential to Maryland's expansion of these evidence-based practices, it is not the sole solution. Not all children in need of these practices are eligible for Maryland Medical Assistance. As discussed at p. 21, it would still be cost effective for the State to make these practices available to a broader group of delinquent children.

⁶ Buck, J., *Medicaid, Health Care Financing Trends, and the Future of State-based Public Mental Health Services*, Psychiatric Services, 2003.

⁷ Data from MHA is available upon request to MDLC. MHA paid out at least \$187,975,574 for children's Medicaid services, \$8,534,047 in state grant funds for children's services, and an estimated \$3,862,195 in federal block grant funds for children's services.

⁸ *Turning Knowledge Into Practice, A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practice*, The Technical Assistance Collaborative, Fall 2003, at 15, hereinafter cited as "*Turning Knowledge Into Practice*."

⁹ www.mstservices.com/text/treatment.html; www.mtfc.com/history.html.

¹⁰ <http://www.colorado.edu/cspv/blueprints/>.

¹¹ The other eight model programs are: Midwestern Prevention Project, Big Brothers Big Sisters of America, Life Skills Training, Nurse-Family Partnership, Olweus Bullying Prevention Program, Promoting Alternative Thinking Strategies, The Incredible Years: Parent, Teacher and Child Training Series and Project Toward No Drug Abuse.

¹² *Turning Knowledge Into Practice* at 49.

¹³ *Youth Violence: A Report of the Surgeon General*, U. S. Department of Health and Human Services, 2001, hereinafter cited as "*Youth Violence: A Report of the Surgeon General*" at <http://www.surgeongeneral.gov/library/youthviolence/toc.html>.

¹⁴ *Substance Abuse and Mental Health Services Administration Model Programs*, U.S. Department of Health and Human Services, http://modelprograms.samhsa.gov/template_cf.cfm?page=model_list; Hawaii Department of Health, Child and Adolescent Mental Health Division/ Evidence Based Services Committee, Biennial Report (Fall 2000) www.state.hi.us/doh/camhd/index.html; *Mental Health: A Report of the Surgeon General*, U.S. Dept. of Health and Human Services (1999), hereinafter cited as "*Mental Health: A*

Report of the Surgeon General” at <http://www.surgeongeneral.gov/library/mentalhealth/home.html> ; Office of Juvenile Justice and Delinquency Prevention, <http://ojjdp.ncjrs.org/>, www.dsgonline.com/mpg2.5 ; National Institute on Drug Abuse (1999), *Principles of drug addiction treatment: A research-based guide*. NIH Publication No. 99-4180; National Alliance for the Mentally Ill (NAMI), [Beginnings - A publication dedicated to the Young Minds of America from the NAMI Child & Adolescent Action Center](http://www.nami.org/Content/ContentGroups/Youth/Issue3.pdf), <http://www.nami.org/Content/ContentGroups/Youth/Issue3.pdf>.

¹⁵ While Maryland also has a legal obligation to cover other promising mental health practices for children under Medicaid, such as wraparound services, in this report we address only these three EBPs. See note 124. They were selected because:

- They have been designated gold standard or model programs.
- The evidence of their cost effectiveness is strongest.
- They are designed for a limited population of children with delinquent or anti-social behaviors for whom Maryland has not provided effective mental health services.

¹⁶ Information provided by Keller Strother of MST Services, Inc.

¹⁷ However, when states bill Medicaid for an evidence-based practice, a diagnosis is required.

¹⁸ *Turning Knowledge Into Practice* at 50; and <http://www.colorado.edu/cspv/blueprints/model/programs/FFT.html>.

¹⁹ Weisman, S. & Gottfredson, D., *Maryland Blueprints Manual, A Guide to Promising and Proven Prevention Programs*, University of Maryland Department of Criminology (2003); and information reported by current Maryland FFT providers.

²⁰ *Youth Violence: A Report of the Surgeon General*, Appendix 5-B: Descriptions of Specific Programs That Meet Standards for Model and Promising Categories, at <http://www.surgeongeneral.gov/library/youthviolence/toc.html>.

²¹ <http://www.mstservices.com/>. The age range varies from state to state but this is the age range recommended by MST Services, Inc.

²² Hoagwood, K., *Evidence-based Practices in Child and Adolescent Mental Health: Its Meaning, Application, and Limitations*, NAMI Beginnings, Fall 2003.

²³ *Turning Knowledge Into Practice* at 50.

²⁴ Information provided by MST Programs in Maryland.

²⁵ <http://www.mstservices.com/text/research.html>.

²⁶ www.colorado.edu/cspv/blueprints/model/programs/MTFC.html.

²⁷ *Mental Health: A Report of The Surgeon General*, Chapter 3, at www.surgeongeneral.gov/library/mentalhealth/chapter3/sec7_1.html.

²⁸ Estimate provided by Gerard Bouwman of TFC, Inc. in Eugene, Oregon.

²⁹ www.colorado.edu/cspv/blueprints/model/programs/MTFC.

³⁰ Subcommittee on Evidence-Based Practices of the President's New Freedom Commission on Mental Health, Background Paper, April 2005, at 3, hereinafter cited as "Subcommittee on Evidence-Based Practices" at http://www.mentalhealthcommission.gov/reports/EBP_Final_040605.pdf.

³¹ <http://www.nri-inc.org/CMHQA.cfm>.

³² Subcommittee on Evidence-Based Practices at 23, at http://www.mentalhealthcommission.gov/reports/EBP_Final_040605.pdf.

³³ See Appendix A.

³⁴ http://www.mentalhealthcommission.gov/subcommittee/MEDICAID_013103.doc.

³⁵ <http://www.nri-inc.org/CMHQA.cfm>.

³⁶ The number climbed from 23,591 children in FY 1998 to 45,755 in FY 2006. The Public Mental Health System provides services to slightly under 10% of all children in the State eligible for Medical Assistance. See Analysis of the FY 2007 Maryland Executive Budget, Mental Hygiene Administration at 8, 2006.

³⁷ Ringel, J.S. & Sturm, R., *National Estimates of Mental Health Utilization for children in 1998*, Journal of Behavioral Health Services & Research (2001)(The percentage of children who need care but do not receive it varies by race with 69% of white children, 78% of African-American children and 86% of Hispanic children not receiving needed mental health services.); *Maryland An Assessment of Access to Counsel and Quality of Representation in Delinquency Proceedings*, American Bar Association, October 2003 at 13, hereinafter cited as "An Assessment of Access to Counsel" at http://www.soros.org/initiatives/justice/articles_publications/publications/juvenile_indigent_defense_20031001/mdreport.pdf.

³⁸ *Id.*

³⁹ See note 2. Dacmmrich, J., "Psychological Screenings Urged for State's Juvenile Lawbreakers," Baltimore Sun, February 25, 1999. According to DJS data from March 2006, of 4,339 youth coming through DJS intake, 1,939 completed the intake needs screening instrument, and of those youth, only 12% indicated a need for mental health services/referral. Based on the experience of the Baltimore County Bureau of Mental Health MST Program from FY 2003-2006, of the delinquent youth referred to that program, a request for a diagnosis was left blank or answered "unknown" for 36% of the children although there were indicators that many of these youth had a mental illness.

⁴⁰ Community Services Reimbursement Rate Commission Report, June 2005, and additional MHA data available upon request to MDLC.

⁴¹ Data from MHA is available upon request to MDLC.

⁴² Ringel, J.S., and Sturm, R., *National Estimates of Mental Health Expenditures for Children in 1998*, Journal of Behavioral Health Services & Research, August 2001.

⁴³ Friedman, Katz-Leavy, Manderscheid, and Sondheimer, *Prevalence of Serious Emotional Disturbance: An Update*, Center for Mental Health Services, 1998, in Manderscheid, R.W., and Henerson, M.J. eds. DHHS Pub. No. (SMA) 99-3285, U.S. Govt. Print. Off., 1998.

⁴⁴ *Children's Mental Health: Facts for Policymakers*, National Center for Children in Poverty, November 2006, at http://www.nccp.org/pub_ucr06b.html.

⁴⁵ The annual average of 21 outpatient visits was in FY 2004 according to data from MHA, available from MDLC upon request.

⁴⁶ All MHA data in this paragraph is available upon request to MDLC.

⁴⁷ *Id.*

⁴⁸ *An Assessment of Access to Counsel* at 13, 46, 56-57, at http://www.soros.org/initiatives/justice/articles_publications/publications/juvenile_indigent_defense_20031001/mdreport.pdf.

⁴⁹ Even if equivalent services were available, that would not excuse Maryland's failure to cover FFT, MST, or MTFC under Medicaid law. See discussion at p. 25.

⁵⁰ The Act and regulations prohibit federal financial participation "with respect to care or services for any individual who is an inmate of a public institution." See 42 U.S.C. § 1396d(a)(27)(A); 42 C.F.R. §§ 441.33(a)(1), 435.1008 and 435.1009; and Maryland Medicaid Manual at p. 500-10f.

⁵¹ The placement of delinquent youth in detention centers and residential treatment centers has not been proven to be effective as evidenced by Maryland's own recidivism data. See note 3. See also *Youth Violence: A Report of the Surgeon General*; *Mental Health: A Report of the Surgeon General*, Chapter 3; Burns, B., *Effective Treatment for Mental Disorders in Children and Adolescents*, *Clinical Child and Family Psychology Review* (1999); Vaughn, C., *Residential Treatment Centers : Not a Solution for Children with Mental Health Needs*, *Clearinghouse Review Journal of Poverty Law and Policy*, July-August 2005; *Fact Sheet: Children in Residential Treatment Centers* at <http://www.bazelon.org/issues/children/factsheets/rctcs.htm>; Chamberlain, P., Treatment Foster Care, U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, December, 1998.

⁵² "Referrals" means the number of juvenile arrests.

⁵³ See Note 2; Analysis of the FY 2007 Executive Budget, Department of Juvenile Services, at 6, 2006.

⁵⁴ "Formal processing" means that DJS sends charges to the State's Attorney that will trigger court hearings.

⁵⁵ Gap Analysis Report, 2004, at iii at http://www.djs.state.md.us/pdf/gap/gap_analysis.html.

⁵⁶ This is the number of children Maryland MST and FFT programs reported as receiving services or being targeted to receive services in FY 2006. Of the 234 children, 121 received MST (11 in Baltimore City, 41 in Baltimore County, 49 in Prince George's County, and 20 in Frederick), and 113 received FFT (48 in Baltimore City and 65 in Charles and St. Mary's Counties).

⁵⁷ *Key Issues*, National Center for Mental Health and Juvenile Justice, Key Issue 4 at <http://www.ncmhjj.com/faqs/default.asp>.

⁵⁸ While DJS does not currently maintain data on the percentage of children entering its system who are on Medical Assistance, other information suggests the percentage of children on Medical Assistance in this population is very high. See Analysis of the FY 2002 Operating Budget, Department of Juvenile Justice, at 16 (2001); Testimony of Maryland Juvenile Justice Coalition in Support of HB 692 (March 12, 1999). In addition, while 40% of the children residing in Baltimore City are eligible for Medicaid, we have received estimates that 85-100% of the children referred for MST or FFT in Baltimore City are on Medicaid. In Baltimore County, over 43% of the youth referred to their MST program were on Medicaid, also higher than the percentage of youth eligible for Medicaid in the population.

⁵⁹ Analysis of the FY 2006 Executive Budget, Department of Juvenile Services at 32, 2005; Analysis of the FY 2005 Executive Budget, Department of Juvenile Services at 32, 2004.

⁶⁰ Analysis of the FY 2007 Executive Budget, Department of Juvenile Services at 1, 2006.

⁶¹ *Choice\$ & Challenge\$*, Advocates for Children and Youth, 2005 at http://www.sustainfunds.org/choices/finding_alternatives.pdf.

⁶² Analysis of the FY 2005 Executive Budget, Department of Juvenile Services at 32, 2004.

⁶³ FY 2007 DJS Operating Budget at III-658 at http://dbm.maryland.gov/dbm_publishing/public_content/dbm_search/budget/tocfy2007operbudgetdetail/juvserv.pdf. Of the 1,747 children, 253 were in secure detention, 130 were committed to DJS and in detention pending placement, 99 were in other secure programs, 74 were in shelter care, 210 were in non-secure or staff secure programs, 50 were in foster care, 532 were in group homes, 123 were in substance abuse treatment, and 276 were in psychiatric residential treatment centers. An additional 549 children were being managed by DJS through non-residential alternatives such as community detention, electronic monitoring, or reporting centers.

⁶⁴ *Choice\$ & Challenge\$*, Advocates for Children and Youth, 2005 at http://www.sustainfunds.org/choices/finding_alternatives.pdf.

⁶⁵ *Evaluation of Residential Resources for Children in Maryland*, February 27, 2004, Submitted to The Governor's Office for Children, Youth and Families by REDA International at 5-9, hereinafter cited as "*REDA Report*" and information provided by Jim McComb, Director of the Maryland Association of Resources for Families and Youth (MARFY). However information from the 2005 Department of Legislative Services Analysis of the FY 2006 Executive Budget for the Mental Hygiene Administration at 26 states that a third of the youth in residential treatment centers are DJS referred youth.

⁶⁶ *Report of the Governor's Council on Parental Relinquishment of Custody to Obtain Health Care Services at 46*, 2003. But the *REDA Report* identified a lower cost, stating that the average annual cost for a Maryland RTC at this same time was \$122,468 *excluding* education costs. It is possible that education program costs account for much of the difference in RTC costs between these two reports.

⁶⁷ MHA data available upon request to MDLC.

⁶⁸ *Choice\$ & Challenge\$*, Advocates for Children and Youth, 2005 at http://www.sustainfunds.org/choices/finding_alternatives.pdf.

⁶⁹ Information obtained from Baltimore County Bureau of Mental Health, Prince George's County Department of Family Services, and Family League of Baltimore.

⁷⁰ Gap Analysis Report, 2004, at xxiii at http://www.djs.state.md.us/pdf/gap/gap_analysis.html.

⁷¹ Analysis of the FY 2007 Executive Budget, Department of Juvenile Services at 15, ex. 8 (2006).

⁷² Gap Analysis Report, 2004, at iv at http://www.djs.state.md.us/pdf/gap/gap_analysis.html.

⁷³ Gap Analysis Report, 2004, at 8-20, 8-25 at http://www.djs.state.md.us/pdf/gap/gap_analysis.html.

⁷⁴ MHA data available upon request to MDLC.

⁷⁵ <http://www.djs.state.md.us/cripa.html>.

⁷⁶ Analysis of the FY 2007 Executive Budget, Department of Juvenile Services, at 44-45 (2006). See also the report available on the DJS website, *The Disproportionate Representation of African-American Youth at Various Decision Points in the State of Maryland*, <http://www.djs.state.md.us/pdf/dispro-report.pdf> and the data on Maryland at <http://www.buildingblocksfor youth.org/statebystate/mddmc.html>.

⁷⁷ Information provided by Linda Heisner, Deputy Director of Advocates for Children and Youth.

⁷⁸ *Olmstead Planning for Children with Serious Emotional Disturbance: Merging System of Care Principles with Civil Rights Law*, Bazelon Center for Mental Health Law, at 5, 2001 at <http://www.bazelon.org/issues/children/publications/mergingsystems/olmsteadchildren2.pdf>.

⁷⁹ <http://www.djs.state.md.us/cripa.html>.

⁸⁰ The problems noted in this paragraph are based on MDLC's experience in representing children to obtain special education services.

⁸¹ All information about the Baltimore County MST Program in this report has been provided by Lee Ohnmacht, an employee of the Baltimore County Bureau of Mental Health and the project director.

⁸² Baltimore County Annual Research Report for FY 2005, University of Maryland at Baltimore County, October 11, 2005, available upon request.

⁸³ The vignette in Appendix B was prepared by Judy Kinsella, Ph.D., the MST Program Manager for Psychotherapeutic Treatment Service, Inc. for their August 2006 annual report.

⁸⁴ Baltimore County is working with "Maryland Opportunity Compact," a financial strategy which uses private funds for public projects, developed by the "More for Maryland Campaign," headed by Baltimore's Safe and Sound Program.

⁸⁵ Information provided by Baltimore County Bureau of Mental Health and Baltimore City Health Department.

⁸⁶ Information provided by Vicky Mitchell, Assistant Secretary at DJS.

⁸⁷ Information in this paragraph provided by The Prince George's County Department of Family Services and Douglas Mohler from DJS.

⁸⁸ Information in this paragraph provided by Jennifer Lilly from Way Station, Inc.

⁸⁹ Information provided by John Fullmer, the Anne Arundel County Juvenile Drug Court Coordinator.

⁹⁰ Information in this paragraph and the preceding paragraph provided by Vicky Mitchell, Assistant Secretary at DJS and Larry Dawson, Youth Development Coordinator, Family League of Baltimore City.

⁹¹ Information in this paragraph provided by Catherine Meyers, Executive Director of The Center For Children, Inc.

⁹² SPA 04-19 as approved by the Center for Medicare and Medicaid Services is available upon request to MDLC.

⁹³ Study is available upon request to MDLC.

⁹⁴ State action to revamp access to our existing treatment foster care service is also needed. DHMH has provided these Medicaid services only to children in the care or custody of DJS or a local Department of Social Services but has not made these entitlement services available to all Medicaid recipients who are

eligible. MDLC sent a letter to DHMH's Medicaid director on October 18, 2006 raising this legal violation and asking DHMH to correct it by, among other steps, implementing a process for recipients not in the care or custody of the State to be referred to the Department of Human Resources or DJS for consideration of their eligibility for residential rehabilitation services including treatment foster care. We have not received any reply. DHMH must address this problem to ensure all Medicaid recipients can access the treatment foster care service as it implements a multidimensional treatment foster care component.

⁹⁵The states now billing MST to Medicaid are Alabama, Arizona, California, Colorado, Georgia, Maine, Michigan, Nebraska, New Mexico, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, and Wyoming. Connecticut had previously billed MST to Medicaid and plans to do so again. Hawaii is planning to bill MST to Medicaid.

⁹⁶ California, Maine, New Mexico, New York, and Pennsylvania are billing FFT to Medicaid.

⁹⁷*Medicaid Support of Evidence-Based Practices in Mental Health Programs*, a technical assistance paper prepared jointly by SAMSHA and CMS, at <http://www.medicine.uiowa.edu/icmh/evidence/documents/Medicaid-support-forebps.pdf>; Subcommittee on Evidence-Based Practices at 23, at http://www.mentalhealthcommission.gov/reports/EBP_Final_040605.pdf.

⁹⁸ Billing information provided by state agency representatives, MST providers in the listed states, and MST Services Inc.

⁹⁹ See Appendix C.

¹⁰⁰ Hawaii has made a request to CMS to start billing MST under H2033.

¹⁰¹ Information regarding state billing practices provided by state agency representatives, MST providers in the listed states, or MST Services, Inc.

¹⁰² www.fftinc.com.

¹⁰³ Information provided by state agency representatives or FFT providers in the listed states.

¹⁰⁴ *Youth Violence: A Report of the Surgeon General*, Chapter 6 at <http://www.surgeongeneral.gov/library/youthviolence/toc.html>.

¹⁰⁵ 42 C.F.R. § 431.51(b) and (c).

¹⁰⁶ For example, the names "Multidimensional Treatment Foster Care" and "MTFC" are registered trademarks and their use is only granted to programs that are receiving implementation services from TFC, Consultants, Inc. in Salem, Oregon and programs that have been certified by The Center for Research to Practice in Eugene, Oregon.

¹⁰⁷ Just as with FFT and MST, not all components of MTFC are Medicaid billable. For example, the room and board component of MTFC is excluded from federal financial reimbursement.

¹⁰⁸ This is supported by a comparison of the locations providing MTFC at <http://www.mtfc.com/current.html> with the twenty states listed in *Katie A. v. Bonta*, 433 F.Supp.2d 1065, 1076 n.14 (C.D. Ca. 2006) that were providing treatment foster care under Medicaid.

¹⁰⁹ Information in this paragraph was provided to MDLC by Gerard Bouwman of TFC, Consultants, Inc. in Salem, Oregon. See <http://www.mtfc.com/>.

¹¹⁰ *Key Issues*, National Center for Mental Health and Juvenile Justice, Key Issue 5 at <http://www.ncmhjj.com/faqs/default.asp>.

¹¹¹ <http://www.wsipp.wa.gov/pub.asp?docid=01-05-1201>.

¹¹² Raeburn, P., *Home Remedy*, New York Times Magazine at 22, May 28, 2006.

¹¹³ *Id.*

¹¹⁴ Data available upon request to MDLC or Baltimore County Bureau of Mental Health.

¹¹⁵ Data available upon request to MDLC or Prince George's County Department of Family Services.

¹¹⁶ *See* note 50.

¹¹⁷ Analysis of the FY 2004 Operating Budget, Department of Juvenile Justice at 23, 2002; Analysis of the FY 2002 Operating Budget, Department of Juvenile Justice at 25, 2001.

¹¹⁸ Analysis of the FY 2006 Executive Budget, Mental Hygiene Administration at 12, 2005; Analysis of the FY 2007 Executive Budget, Mental Hygiene Administration at 11, 2006.

¹¹⁹ *Watching the Bottom Line: Cost-Effective Interventions for Reducing Crime in Washington*, Washington State Institute for Public Policy, January 1998, at www.wsipp.wa.gov/rptfiles/98-01-1201.pdf.

¹²⁰ *See* Appendix A.

¹²¹ Information provided by DJS Assistant Secretary Vicky Mitchell. Only children under DJS supervision at risk of out-of-home placement are eligible rather than a broader group of youth who would meet the established clinical criteria for FFT or MST, such as those who have been referred to DJS, those who have not been referred but who are currently engaging in delinquent behavior, or those at risk of such behavior (FFT only).

¹²² Analysis of the FY 2007 Executive Budget, Mental Hygiene Administration at 35, 2006.

¹²³ *See* Note 51 regarding effectiveness for residential treatment centers. While Maryland Medicaid must cover the EBPs in this report, we do not suggest that the State could stop covering any mental health or physical health care services because they are not EBPs. On a practical level, this would not be realistic because most of the mental and physical health care services that people rely upon today do not yet have an evidence base. Moreover, the Medicaid Act does not permit a State to deny services that fall within the coverage of the Act simply because the service does *not* have an evidence base to demonstrate its effectiveness. In *Jackson v. Millstone*, 369 Md. 575, 600 (2002), the Maryland Court of Appeals found invalid part of a DHMH Medicaid regulation that was used to deny approval of liver transplant surgery for children based on consideration of the "appropriateness" and "effectiveness" of the treatment. The Court found that Maryland had no discretion to use such an effectiveness test in deciding whether a person under 21 was eligible for medical services because the federal EPSDT statute made no mention of using such a standard. The Court found the only legitimate reason for Maryland Medicaid to deny a *covered* healthcare service to someone under 21 is the lack of medical necessity.

¹²⁴ Wraparound services that were the subject of the court's decision in *Katie A.* are considered a promising practice rather than an EBP. Maryland has begun an initiative to deliver wraparound services to a limited number of children in Baltimore City and Montgomery County. In February 2006, DHMH submitted a waiver amendment application to CMS to provide wraparound under a bundled case rate for up to 750 children who meet residential treatment center level of care. The application is still pending. Even this initiative would not satisfy the Court's recent decision in *Katie A. v. Bonta*, holding that wraparound

services fall within the EPSDT provisions of the Medicaid Act and must be provided where medically necessary to *all* children on Medicaid.

Family psycho-education is recognized as an EBP for adults but is being provided by other states such as North Carolina and Maine to families of children with mental illness as well. In Maryland, family psycho-education is being implemented for adults but it does not appear to be a recognized children's service listed in our regulations or Public Mental Health System Provider Manual. The denial of family psycho-education services to children in Maryland also is legally problematic.

¹²⁵ See Dear State Medicaid Director Letter, Olmstead Update No. 4 at 11, January 10, 2001, at <http://www.cms.hhs.gov/smdl/downloads/smd011001a.pdf>.

¹²⁶ See Appendix C.

APPENDIX A:

CITY OF BALTIMORE

MARTIN O'MALLEY, Mayor



HEALTH DEPARTMENT

JOSHUA M. SHARFSTEIN, M.D., Commissioner
210 Guilford Avenue
Baltimore, MD 21202

October 13, 2006

Susan Steinberg
Deputy Secretary for Health Care Financing
Department of Health and Mental Hygiene
201 West Preston Street, 5th Floor
Baltimore, MD 21201

Dear Ms. Steinberg:

We are writing to request that the Maryland Medicaid Program include Multisystemic Therapy in the continuum of services offered to children and youth within the public mental health system. Multisystemic Therapy is a nationally recognized best practice for treating youth suffering from serious emotional disturbance and has been proven successful at reducing out of home placements, decreasing substance abuse, and increasing positive family and child outcomes. This is a unique intervention that does not fit within any of Maryland's current service categories. As a result, adding Multisystemic Therapy to the continuum of service will require both regulatory change and a state plan amendment.

Multisystemic Therapy

Multisystemic Therapy, commonly known as MST, is an intensive family- and community-based treatment for youth presenting with serious emotional disturbance, including substance abuse problems, major conduct disorders, and other problems, who are at risk of out-of-home placement.¹ The intervention assists patients to function in their natural settings – home, school and neighborhood – in order to reduce rearrest, substance abuse, and out-of-home placements and improve family functioning in the long term. Therapists seek to build on youth and family strengths (protective factors) in order to attenuate risk factors. The treatment empowers parents with the skills and resources to promote the child's success in the family, school and community.

MST is an evidence-based practice with a two-decade record of success that has been recognized by the Surgeon General, National Institutes on Drug Abuse, National Institutes of Health, Center for Substance Abuse Prevention, and President's New Freedom Commission on Mental Health.²

¹ Definition of "serious emotional disturbance" from the United States Department of Health and Human Services report "Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances" (June 2006), page 1 "Youth with [Serious Emotional Disturbance] include children and adolescents with chronic depression, major conduct disorders, substance abuse problems, and other behaviors that are challenging to families and communities."

² See U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health; U.S. Public Health Service (2001). *Youth violence: A report of the Surgeon General*. Washington, DC: National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide*. NIH Publication No. 99-4180; National Institutes of Health (2004). *Preventing violence and related health-risking social behaviors in adolescents: An NIH State-of-the-Science Conference*. Bethesda, MD; Center for Substance Abuse Prevention (CSAP) (2000). *Strengthening America's families: Model family programs for substance abuse and delinquency prevention*. Salt Lake City, Utah: Department of Health Promotion and Education, University of Utah; and President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America -- Final Report*. Rockville, MD: DHHS.

It has been proven effective in both urban and rural settings. One study of a cohort of chronic juvenile offenders in Columbia, Missouri showed decreased psychiatric symptomatology and recidivism four years post treatment;³ these youth also demonstrated 54% fewer rearrests and 57% fewer days of incarceration compared to youth undergoing individual counseling nearly 14 years post-treatment.⁴ Another study showed significantly increased rates of marijuana abstinence among substance abusing and dependent juveniles four years post treatment.⁵ Most recently, a study of youth in Hawaii with serious emotional disturbance demonstrated that youth enrolled in MST showed significantly improved externalizing and internalizing symptoms and significantly fewer days in out-of-home placement compared to youth in standard services.⁶ Finally, the Washington State Institute for Public Policy found that the crime reductions attributable to MST yielded \$2.64 for each dollar invested in the program.⁷

In Maryland, Baltimore County has provided MST since FY03 and has demonstrated considerable success in reducing both psychiatric symptomatology and externalizing behavior. Most notably, participants have demonstrated 64.6% fewer arrests, compared to pretreatment numbers (Attachment A).

Medicaid and MST

The effectiveness of MST as treatment for children with serious emotional disturbance has led an increasing number of states to add MST to their Medicaid programs. Within the past year, the Department of Health and Human Services (DHHS) has approved state plan amendments for North Carolina and New Mexico that add MST as a covered service using the "rehabilitation" option (42 CFR §440.130(d)). Both states use the existing HCPCS code for MST (H2033).

The rehabilitation option has several advantages over other methods for partially or fully funding MST through Medicaid. It ensures that MST providers are held to regulatory standards that mirror the model and promote fidelity, rather than requiring them to meet requirements designed for other treatment providers (such as mobile treatment). It greatly reduces or eliminates the need for providers to seek supplemental funding from other state agencies, reducing the administrative burden on existing providers and encouraging new providers to offer services. Most importantly, unlike a waiver, it permits all Medicaid-eligible children who need the service to access it through their primary care providers.

Over the past decade, several lawsuits have been filed based on states' failure to provide adequate behavioral and mental health services for Medicaid eligible youth suffering from serious emotional disturbance. Courts have interpreted the statutory mandate that state Medicaid programs provide Early and Periodic Screening Diagnosis and Treatment (EPSDT) (42 USC §1396a(a)(43)) to require that states provide Medicaid-eligible youth suffering from serious emotional disturbance with in-home behavioral services that have been demonstrated effective,

³ Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, 63, 569-578.

⁴ Schaeffer, C. M., & Borduin, C. M. (2005). Long-Term Follow-Up to a Randomized Clinical Trial of Multisystemic Therapy With Serious and Violent Juvenile Offenders. *Journal of Consulting and Clinical Psychology*, 73(3), 445-453.

⁵ Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G. (2002). Four-year follow-up of multisystemic therapy with substance abusing and dependent juvenile offenders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 868-874.

⁶ Rowland, M.D., Halliday-Boykins, C.A., Henggeler, S.W., Cunningham, P.B., Lee, T.G., Kruesi, M.J.P., & Shapiro, S.B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix Class youths. *Journal of Emotional and Behavioral Disorders*, 13 (1), 13-23.

⁷ Aos, S., et. al. Benefits and costs of prevention and early intervention programs for youth. Washington State Institute for Public Policy; September 17, 2004. <http://www.wsipp.wa.gov/pub.asp?docid=04-07-3901>

including services that assist youths' families to better handle their children's behavioral problems. In *Rosie D. v. Romney*, Massachusetts 410 F.Supp. 2d 17 (D. Mass., 2006), the Court found that the Massachusetts failed to provide adequate EPSDT services to youth with serious emotional disturbance, in large part because it failed to make evidence-based in-home services available to youth and their families. Likewise, in *Katie A. v. Bonta* 433 F. Supp 2d 1065 (C.D. Cal., 2006), the Court issued a preliminary injunction requiring the State to provide "wraparound" services (which the Court defined to include a variety of home- and family-based services) to youth with serious emotional disturbance. These decisions come in the wake of earlier court cases, including *Kirk T. v. Houston* (E.D. Pa., 2000) and *J.K. v. Eden* (Arizona, 2001)⁸, which resulted in settlements that required States to provide in-home behavioral health services and, in Arizona, explicitly required that evidenced based practices be incorporated into services provided under Medicaid.

Requested Action by Maryland

Our state has already demonstrated laudable commitment to providing evidence-based practices through the public mental health system. From encouraging the provision of Assertive Community Treatment to adults by providing an enhanced "Evidenced Based Practice" rate for services that adhere to the model, to successfully applying for a waiver to fund the Wraparound Model, the Department of Health and Mental Hygiene (DHMH) has taken concrete steps to enhance the quality of services available to beneficiaries.

In order to continue Maryland's commitment to excellence in mental health services, we request that Maryland add MST to the services offered to youth in the public mental health system. We believe that this will require the following steps:

1. **Add Multisystemic Therapy to the Mental Hygiene Regulations (COMAR 10.21) as a Community Mental Health Program.** Unlike Assertive Community Treatment, which had requirements that closely mirrored those for programs offering Mobile Treatment Services pursuant to COMAR 10.21.19, MST staffing and service requirements do not fit well within any existing service classifications. Based on the service description used by New Mexico (Attachment B), existing classifications are inappropriate and would impose unnecessary requirements on MST providers. We recommend using the model service description to draft any new regulation, including the requirement that MST providers must maintain a license with MST Services, Inc. in order to ensure continued fidelity to the model.
2. **Request a State Plan Amendment to include Multisystemic Therapy as a covered service in Maryland's Medical Assistance Program.** DHHS has already demonstrated its willingness to grant such an amendment, as demonstrated in North Carolina and New Mexico earlier this year. Ideally, the Amendment would provide for MST to be reimbursed at a case-rate, but we recognize that DHHS may be less likely to grant such a request. Using the existing HCPCS code, which allows billing for MST services in 15-minute increments, would be acceptable.
3. **Work with the Department of Juvenile Services to develop a cost sharing arrangement to supply the State match.** The documented cost savings of MST come almost entirely from reductions in crime and decreases in out of home juvenile justice placements. Indeed, part of the recommended eligibility criteria (Attachment B) is that

⁸ Settlement agreement available at www.hazeon.org/issues/children/incourt/jk/jk_settlementagreement.pdf

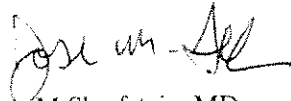
the youth demonstrate delinquent behavior and be at imminent risk of out of home placement due to that behavior. Because the Department of Juvenile Services is likely to yield the greatest budgetary savings from making this treatment available to Medicaid eligible juvenile offenders with serious emotional disturbance, it would be reasonable for the Department to contribute a portion of the State match. This will help to relieve any financial burden imposed on DHMH as a result of adding MST as a covered service.

We also recommend that DHMH consider making additional evidence-based practices for the treatment of youth with serious emotional disturbance, such as Functional Family Therapy, available to all Medicaid-eligible youth in Maryland. This would be especially prudent in light of recent legal developments throughout the country finding that Medicaid-eligible youth with serious emotional disturbance are entitled to evidence-based in-home services.

We are prepared to assist DHMH in any way necessary to make this vitally important service available to all Maryland youth.

We look forward to working with you on this important project.

Sincerely,



Joshua M Sharfstein, MD
Commissioner of Health for Baltimore City



Pierre Vigilance, MD
Health Officer for Baltimore County

cc: S. Anthony McCann
Kenneth C. Montague, Jr.
Brian Hepburn
Al Zachik

APPENDIX B:

Multisystemic Therapy Case Vignette Baltimore County MST Program

The Baltimore County Drug Court referred a 15 year-old Hispanic male with diagnoses of depressive disorder NOS and Cannabis, Alcohol, and Cocaine Abuse. His referral behaviors included alcohol use, smoking marijuana, hanging out with negative peers, missing school, noncompliance with house rules and being verbally disrespectful to adults. He had been arrested two times with charges for petty theft, malicious destruction of property and CDS possession, and had three prior admissions to substance abuse treatment programs. Initially the youth's mother was a reluctant participant in the MST Program. She would avoid meeting with the therapist by not answering cell phone calls, stating she was working a double shift and other excuses. The therapist was very flexible and offered to meet with the mother while the youth was engaged in some of his Drug Court meetings. The mother scheduled one meeting at 8 a.m. and when the therapist showed up for that meeting, it was obvious both she and her son had just awakened. The therapist sensed that the mother said that they should meet at that hour as a way to deter her. But when the therapist demonstrated that she was willing to do whatever the family needed, the barriers to treatment seemed to decrease. After that visit, there were no more issues around scheduling appointments.

Mother had a cultural belief that it was okay for the youth to drink alcohol because that is what she believed the males do in Panama, her native land. The therapist worked very diligently to get mother to understand the seriousness of this youth's alcohol use. He had progressed to the point where his consumption of alcohol resulted in him passing out. Thus his use was a real threat to his life. The youth got drunk one time during treatment and then became very committed to being sober. The youth would miss school by not getting up in time to catch the bus. When arrangements were made that changed the youth's morning routine, he was attending school on a regular basis. He did so well at the alternative high school, that when he returns to his home school, he will have enough credits to participate in a program that will train him as an auto mechanic. The youth has had many positive experiences as a result of being sober and this has reinforced his commitment. The youth was working at a fast food restaurant and also for a catering service. His work experiences were positive and he was a reliable worker. At the time of discharge from the MST Program there had been no drug use for seven (7) weeks, the youth missed school once, he was gaining friends from a different peer group, he was being compliant with the Drug Court requirements and house rules, and he was being respectful towards his mother.

APPENDIX C: NORTH CAROLINA MEDICAID STATE PLAN
AMENDMENT FOR MULTISYSTEMIC THERAPY

Attachment 3.1-A.1
Page 7c.7

4.b.(8) Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services (continued)
Description of Services

(h) Multisystemic Therapy (MST)

This mental health/substance abuse program is designed for youth generally between the ages of 7 and 17 who have antisocial, aggressive/violent behaviors and are at risk for out of home placement due to delinquency; adjudicated youth returning from out of home placement and/or chronic or violent juvenile offenders; and youths with serious emotional disturbances or abusing substances. This is a team service that has the ability to provide service 24/7/365. The services include assessment, individual therapeutic interventions with the youth and family, case management, and crisis stabilization. Specialized therapeutic interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. The service must be ordered by a physician, licensed psychologists, physician's assistant or nurse practitioner and prior approval will be required via the statewide UR vendor or by an approved LME contracted with the Medicaid Agency and meeting the same standards and requirements as the statewide vendor. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

A minimum of 12 contacts are required within the first month of the service and for the next two months an average of 6 contacts per month will occur. It is the expectation that service frequency will be titrated over the last two months. Documentation must include: a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Clinical criteria (medical necessity criteria for admission and continued stay) are embedded in the service definition. The provider qualifications are at a minimum a master's level QP who is the team supervisor and three QP staff. Staff is required to participate in MST introductory training and quarterly training on topics related to the needs of MST youth and their family on an ongoing basis. All MST staff shall receive a minimum of one hour of group supervision and one hour of telephone consultation per week from specially trained MST supervisors. Limitations are in place to prevent reimbursement for duplication of services.

TN No.: 05-005
Supersedes
TN No.: NEW

Approval Date: 12/29/05

Effective Date: 01/01/06