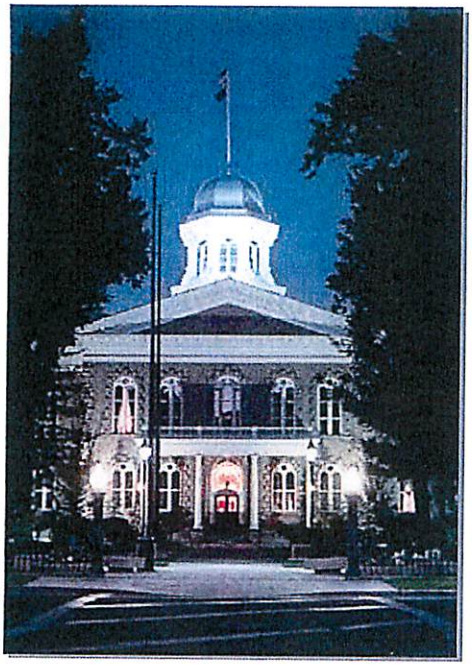


State of Nevada
Governor's Finance Office
Division of Internal Audits

Audit Report

Department of Health and Human Services
Division of Child and Family Services
Child Mental Health Services

Report No. 16-08
June 2016

EXECUTIVE SUMMARY
Division of Child and Family Services
Mental Health Services

Objective: Can DCFS Improve Mental Health Services for Children and Youth by Transforming Treatment Strategies?

Transitioning to home and community based services (HCBS) strategies for children and youth with serious emotional disorders (SED) would lower utilization of more costly residential treatment center (RTC) services, may improve outcomes, and could lower costs by over $19 million annually. Over 300 Nevada children and youth, ages 8 through 20 years of age, are placed in RTCs at great expense to the state. State Medicaid claims data shows less than 1 percent of all behavior health members (children and youth placed in RTCs) use 21 percent of all behavior health spending. Moreover, many young Nevadans are placed outside family settings for more than 6 months, on average, for treatment.

Current system of care issues may lead to unnecessary RTC placements. For many, there is no evidence they received less costly HCBS prior to RTC placement. Federal studies of programs in other states show better outcomes for children, youth, and families who receive more intensive HCBS rather than costlier RTC placements. These studies show successful HCBS programs cost about a third of placing a child or youth in a RTC. Improved outcomes and reduced spending resulted from fewer hospitalizations and emergency room visits, decreased suicide attempts, and decreased clinical symptoms. DCFS' Wraparound in Nevada (WIN) services is an example of a federally recognized, successful, intensive HCBS program helping children and youth in the custody of the state child welfare system. Children and youth in the program have shown improved school attendance, decreased arrests, and fewer suspensions and expulsions.

Modifying the Medicaid state plan will increase HCBS billable services, reduce spending, and improve outcomes for children and youth with serious emotional disorders (SED). New benefit designs can be developed that improve outcomes for children and youth using more cost effective HCBS that include reimbursable services used in other states but not currently part of the Nevada state plan. Current benefits can be redesigned to specifically target children, youth, and families that offer an array of strategies to meet their multiple and changing needs at potentially lower costs. Surveys of other states show three state plan options could be redesigned specifically for children and youth with SED: the 1915(i) Home and Community Based Services; 1915(c) Home and Community Based Services Waivers; and the Health Home State Plan Option.

INTRODUCTION

At the direction of the Executive Branch Audit Committee, we conducted an audit of the Department of Health and Human Services (department), Division of Child and Family Services (DCFS), Child Mental Health Services. Our audit addressed the following four questions:

- ✓ What is the division's role?
- ✓ What services must the division provide?
- ✓ Is the state the proper level of government to provide these services?
- ✓ If state government is the appropriate level of government, is the division carrying out its duties efficiently and effectively?

Our audit focused on the division's child mental health services and use of placements in a residential treatment center (RTC) to address children, youth, and family mental health care needs.

Division's Role and Public Purpose

DCFS is one of five in the department and is funded by the state general fund and federal revenues.[1] DCFS's budget for fiscal year 2015 was approximately $260 million. Exhibit I summarizes DCFS's budget.

[1] Department of Health and Human Services' divisions: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy, Public and Behavior Health, and Welfare and Supportive Services.

Exhibit I

Division of Child and Family Services 2015 Budget

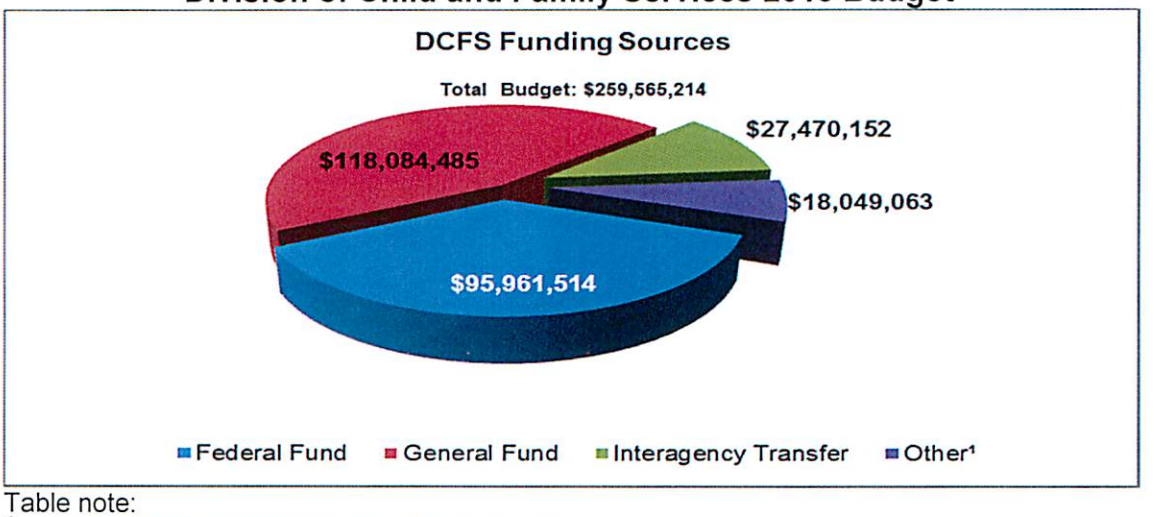
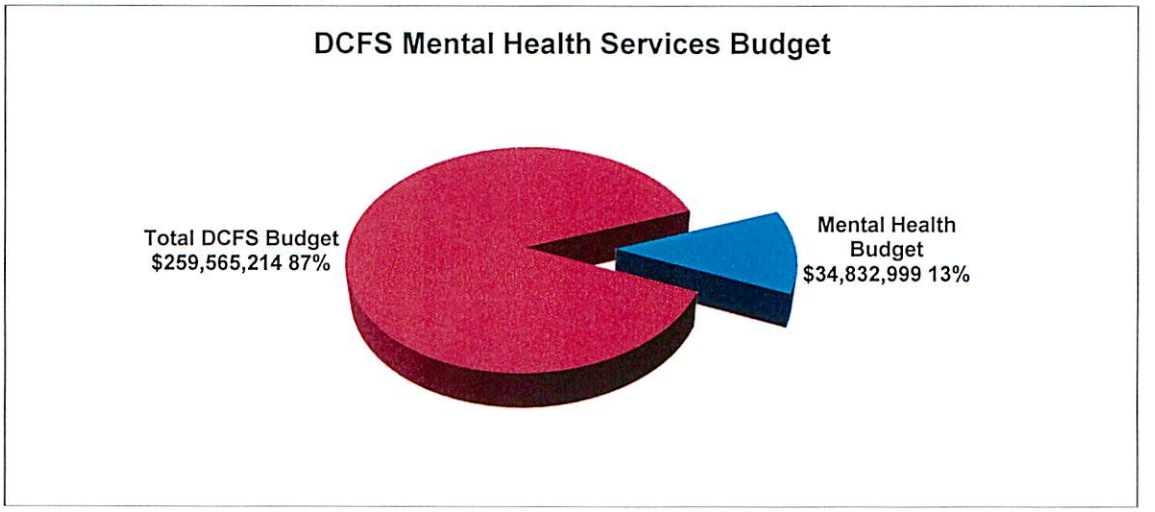


Table note:
[1]Other includes balance forward from prior year.



DCFS is responsible for:

- Child protective and welfare service delivery in rural Nevada;
- Oversight of urban county-operated child protective and welfare services;
- Children and youth's mental health services;
- Outpatient and inpatient acute residential services in urban Nevada; and
- Statewide juvenile justice services including state-operated youth training centers and youth parole.

DCFS has several program areas that include:

- **Child Mental Health Services** provides early childhood services, outpatient therapy, screenings and evaluations, wraparound case management, mobile crisis, and residential and inpatient/acute treatment services.
- **Juvenile Justice Services** provides treatment and community safety, youth rehabilitation and youth commitment to state-operated juvenile facilities, and supervision (parole) of youth upon release to their communities.

- **Child Welfare Services** provides intensive family preservation services, clinical and case management services that respond to caregiver maltreatment/abuse of child, foster care, adoption services, and independent living services.

Child Mental Health Services has offices statewide: Northern Nevada Child and Adolescent Services (NNCAS), Southern Nevada Child and Adolescent Services (SNCAS), and Rural Services. Children and youth are referred by parents, schools, child welfare, juvenile justice, and private and adult mental health providers for mental health services.

Our audit focused on mental health services provided for children and youth placed in RTCs.

Proper Level of Government

The state is the proper level of government to provide these services because they involve oversight of youth mental health programs statewide, which are funded through federal grants and the state general fund.

Objective and Scope

Our audit focused on the following objective:

- ✓ Can DCFS improve mental health services for children and youth by transforming treatment strategies?

We began the audit in December 2015. In the course of our work, we interviewed department and division staff and discussed processes inherent to the division's responsibilities. We reviewed division records from June 2009 through March 2016, applicable Nevada Revised Statutes (NRS), and other state guidelines. We reviewed applicable federal Department of Health and Human Services reports, studies, and recommendations. We also surveyed other states, comparing state outcomes for home and community-based strategies. We concluded field work and testing in May 2016.

We performed our audit in accordance with the *Standards for the Professional Practice of Internal Auditing.*

We express appreciation to the department director, division administrator, deputy administrators, and staff for their cooperation and assistance throughout the audit.

Contributors to this report included:

Warren Lowman
Executive Branch Audit Manager

Lisa Sherych, MBA
Executive Branch Auditor

Division of Child and Family Services
Response and Implementation Plan

We provided draft copies of this report to the department and division officials for their review and comments. Their comments have been considered in the preparation of this report and are included in Appendix A. In its response, the division accepted our recommendations. Appendix B includes a timetable to implement our recommendations.

NRS 353A.090 specifies within six months after the final report is issued to the Executive Branch Audit Committee, the Administrator of the Division of Internal Audits shall evaluate the steps the division has taken to implement the recommendations and shall determine whether the steps are achieving the desired results. The administrator shall report the six month follow-up results to the committee and department officials.

The following report contains our findings, conclusions, and recommendations.

Can DCFS Improve Mental Health Services for Children and Youth by Transforming Treatment Strategies?

DCFS can improve mental health services for children and youth currently placed or at risk of being placed in residential treatment centers (RTCs) by:

- Transitioning treatment strategies from RTC placements to home and community-based services (HCBS); and
- Modifying the Medicaid state plan to develop new benefits and redesign existing benefits for children and youth with serious emotional disorders.

This may improve outcomes for children and youth and reduce state spending by over $19 million annually. Federal research and a limited DCFS program have shown transitioning to HCBS and redesigning the Medicaid state plan may improve outcomes for children, youth, and families while reducing overall spending for treating serious emotional disorders (SED).

Research indicates that children and youth, especially those ages twelve and under should be placed in the least restrictive, most family-like settings possible. Youth who live in institutional settings are at greater risk of developing physical, emotional, and behavioral problems that can lead to school failure, teen pregnancy, homelessness, unemployment and incarceration and are less likely to find a permanent home than those who live and are treated in family settings.[2]

Transition from RTCs to HCBS Strategies

DCFS should transition from RTC placements for children and youth to HCBS strategies to improve outcomes and reduce spending. This could benefit the state by over $19 million annually.

Strategies to prevent RTC placements include more intensive treatments and an array of services within homes and communities than are currently available in Nevada. These strategies support children, youth, and families that are affected by child mental health needs. This will help keep children and youth in their communities and families together.

Nevada children and youth are placed in RTCs when services are either not available or insufficient to meet their treatment needs. Limited capacity and

[2] Research conducted by the National Conference of State Legislatures – Congregate Care, Residential Treatment and Group Home State Legislative Enactments 2009-2013.

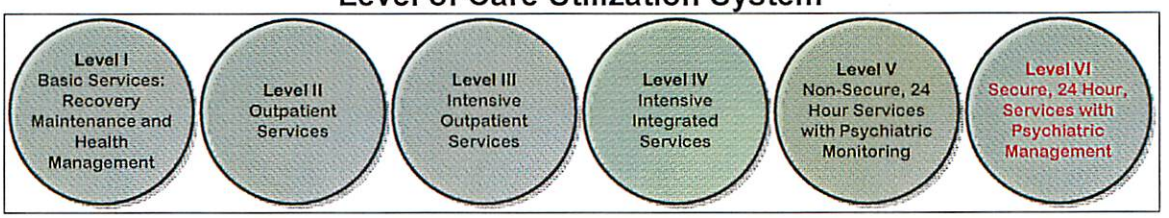
specific treatment needs require many children and youth to be placed in out-of-state (OOS) RTCs.

Over 300 Nevada Children and Youth Are Placed in RTCs at Great Expense to the State

RTCs are secure facilities providing twenty-four hour structured inpatient care, treatment, and supervision for children and youth under age twenty-one with intensity needs of level VI. Exhibit II illustrates the Medicaid approved level of care (LOC) utilization system.[3]

Exhibit II

Level of Care Utilization System



RTCs are designed as a medical model of therapeutic care. Therapies assist children and youth who have behavioral, emotional, psychiatric and/or psychological disorders who have not benefited from, or who are not appropriate for an acute care facility or unsecured lower level of care.

As of June 2015, there were about 330 Nevada fee-for-service Medicaid children and youth, ages 8 through 20 years of age, placed in RTCs throughout the country.[4] Approximately 40 of these youth fall under the authority of DCFS according to state reporting. The remaining children and youth fall under the authority of Aging and Disability Services Division (ADSD)[5] or fall under parental custody or urban county juvenile probation. See Exhibit III for details on placements throughout the United States.

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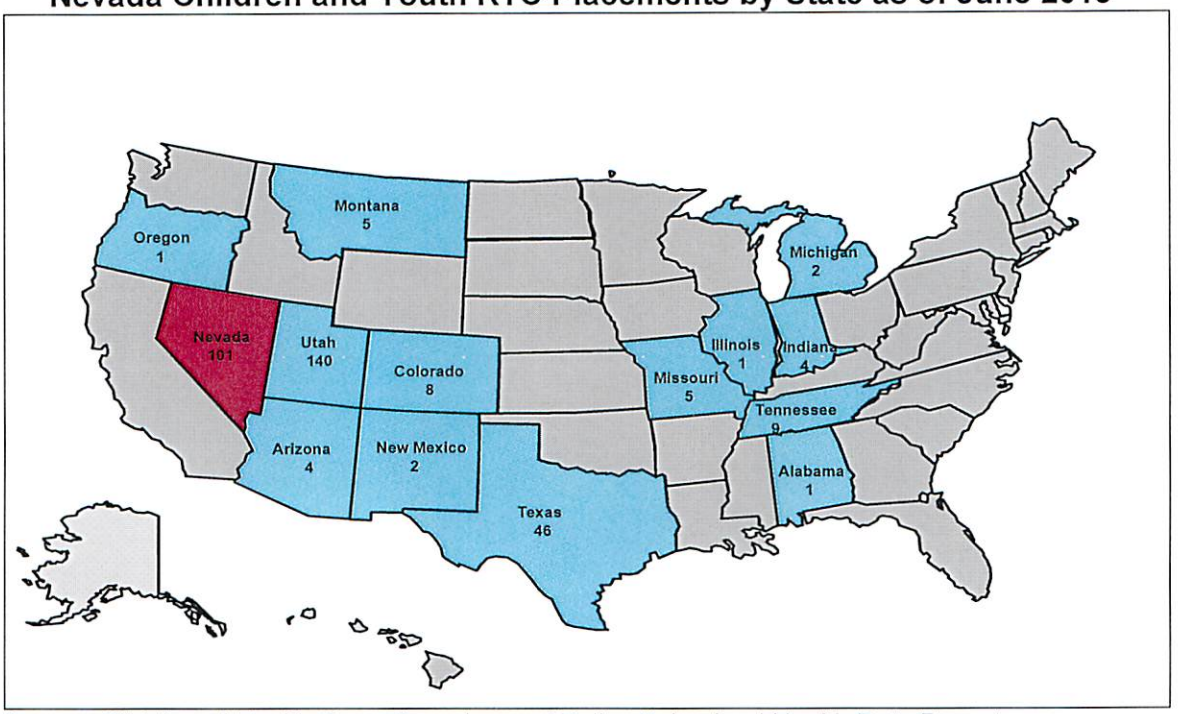
[3] Nevada Medicaid plan.

[4] A fee-for-service delivery system pays providers for each service (ex: office visit, test, or procedure). An alternative system is Medicaid managed care, which provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and Managed Care Organizations (MCOs).

[5] ADSD has 17 children and youth placed in RTCs.

Exhibit III

Nevada Children and Youth RTC Placements by State as of June 2015



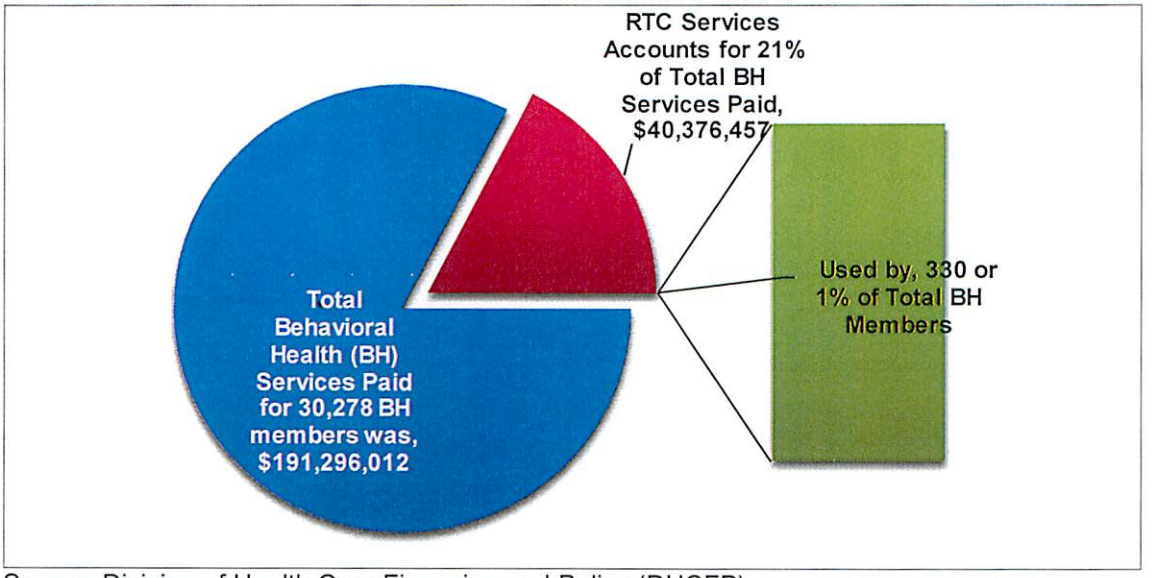
Source: Division of Health Care Financing and Policy Behavioral Health Data Report

In fiscal year 2015, the Division of Health Care Financing and Policy (DHCFP) paid over $191 million in Medicaid payments for behavioral health (BH) services. Out-of-home RTC placement costs were $40,376,457[6] or approximately 21 percent of all BH payments. Moreover, less than 1 percent of all Medicaid BH members received these services.[7] Exhibit IV outlines total RTC cost in comparison to total BH services paid.

[6] See Appendix C.
[7] See Appendix D.

Exhibit IV

Total RTC Services Paid Compared to Total Behavioral Health (BH) Services for Fiscal Year 2015



Source: Division of Health Care Financing and Policy (DHCFP)

RTC Demographics – Many Young Nevadans Placed Outside Family Settings

We reviewed placement data for the past six years through March 31, 2016. There are about 330 children and youth between the ages of 8 to 20 in RTC placement; 23 percent are between the ages of 8 to 12 and not yet teenagers.

Approximately 70 percent of children and youth are in OOS placements. Eleven percent of all OOS placements are children between 8 to 10 years of age. In comparison, five percent of all in-state RTC placements are children between the ages of 8 to 10 years.

System of Care Issues May Lead to Unnecessary RTC Placements

Nevada's mental health system of care for treating children and youth with SED and their families may fall short of preventing some placements outside family and community settings. Data also suggests the system may fall short when children or youth are transitioning back to family and community settings.

Of the Medicaid claims data reviewed for the past six years, we found 27 percent of the children and youth received no HCBS's prior to a RTC placement. We could not determine if children and youth received lower levels of care prior to being placed in RTCs, which is one of the highest levels of care and cost treatment options. Additionally, about 51 percent of children and youth placed in an RTC had no evidence of receiving services after RTC discharge.

No Evidence Some DCFS and Non-DCFS Children and Youth Received HCBS Prior to RTC Placement

Of the 41 children and youth under the authority of DCFS, 17 were in Nevada RTCs and 23 were in OOS RTCs. Medicaid claims data reviewed for the past six years found 10 percent of the DCFS children and youth received no HCBS prior to RTC placement. Thirty-two percent of the non-DCFS children and youth received no HCBS prior to RTC placement.

Some RTC placements may have been avoided if children and youth had received continuity of services. Of the DCFS children and youth who received services prior to RTC placement, two youth had a gap in HCBS of at least four months prior to placement. Additionally, 11 non-DCFS children and youth had a gap in HCBS of at least three months prior to placement. See Exhibit V and VI for an analysis of DCFS and non-DCFS children and youth placed in RTCs.

Exhibit V

Analysis of DCFS Children and Youth Placed in RTCs

Average Age	Total Number of RTC Placements	Average Length of Stay Per RTC	Evidence of HCBS Prior to RTC Placement	
			Yes	No
15	67	7.4 months	90%	10%

Percent of Children (12 and Under)	More Than One RTC Placement	Three or More RTC Placements	RTC Placements	
			Nevada	OOS
12%	32%	15%	51%	49%

Source: DHCFP Claims Data

Exhibit VI

Analysis of Non-DCFS Children and Youth Placed in RTCs

Average Age	Total Number of RTC Placements	Average Length of Stay Per RTC	Evidence of HCBS Prior to RTC Placement	
			Yes	No
14	216	6.5 months	68%	32%

Percent of Children (12 and Under)	More Than One RTC Placement	Three or More RTC Placements	RTC Placements	
			Nevada	OOS
16%	16%	9%	47%	53%

Source: DHCFP Claims Data

Federal Studies Show Better Outcomes for Children, Youth, and Families Who Receive HCBS

The federal government issued a joint informational bulletin in 2013, resulting from several studies, intended to assist states to design a benefit that will meet the needs of children and youth who have significant mental health conditions and in some instances needing psychiatric or residential treatment. The two programs identified in the joint bulletin are: Centers for Medicare and Medicaid Services (CMS) Psychiatric Residential Treatment Facility (PRTF) Demonstration Program and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative (CMHI).[8]

PRTF Demonstration Grant Program

The five-year federal grant PRTF demonstration program that ended September 30, 2012 provided up to $217 million for ten grantee states to use Medicaid funding for HCBS as an alternative to PRTFs for target population youth with mental illness or SED.[9] The demonstration program was designed to determine the effectiveness of HCBS for children and youth who are in or at risk of entering a PRTF and tested the following:

- Whether the demonstration services resulted in the maintenance of, or improvement in, a child's or youth's functional status; and
- Whether it was cost-effective to provide HCBS as an alternative to psychiatric residential treatment.

At the conclusion of the demonstrations, data[10] showed all nine states[11] who fully implemented the demonstration program had an average savings of 68 percent. Consequently, the HCBS cost only 32 percent of comparable services provided in PRTFs.[12] See Exhibit VII for analysis of 68 percent projected savings for Nevada fee-for-service Medicaid RTC placements during FY 2015.

[8] Center for Medicaid & CHIP Services (CMCS) and SAMHSA joint informational bulletin, May 7, 2013.
[9] Target populations included: (1) Children/youth currently living in PRTFs – Transition; (2) Children/youth currently in the community but at risk of institutionalization – Diversion; or (3) A combination of the two.
[10] Data based on first three demonstration years for which cost data was available to be collected.
[11] Alaska, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina, and Virginia.
[12] Medicaid.gov.

Exhibit VII

Federal Cost Savings Estimate for HCBS

	Nevada Residential Treatment Centers				Out-of-State Residential Treatment Centers			
	Number of Children and Youth	Estimated Net Payment[a]	Estimated 68% Savings[b]	Estimated Average Monthly Cost at 32%	Number of Children and Youth	Estimated Net Payment [a]	Estimated 68% Savings[b]	Estimated Average Monthly Cost at 32%
Jul-14	70	$ 785,604	$ 534,211	$ 251,393	175	$ 1,730,938	$ 1,177,038	$ 553,900
Aug-14	66	$ 754,156	$ 512,826	$ 241,330	179	$ 1,704,883	$ 1,159,320	$ 545,563
Sep-14	58	$ 650,056	$ 442,038	$ 208,018	168	$ 1,654,455	$ 1,125,029	$ 529,426
Oct-14	63	$ 703,195	$ 478,173	$ 225,022	179	$ 1,754,494	$ 1,193,056	$ 561,438
Nov-14	69	$ 765,343	$ 520,433	$ 244,910	175	$ 1,720,590	$ 1,170,001	$ 550,589
Dec-14	71	$ 804,264	$ 546,900	$ 257,364	168	$ 1,703,587	$ 1,158,439	$ 545,148
Jan-15	74	$ 855,586	$ 581,798	$ 273,788	161	$ 1,639,593	$ 1,114,923	$ 524,670
Feb-15	73	$ 777,814	$ 528,914	$ 248,900	162	$ 1,454,837	$ 989,289	$ 465,548
Mar-15	75	$ 850,455	$ 578,309	$ 272,146	165	$ 1,645,080	$ 1,118,654	$ 526,426
Apr-15	82	$ 818,175	$ 556,359	$ 261,816	164	$ 1,573,148	$ 1,069,741	$ 503,407
May-15	78	$ 888,809	$ 604,390	$ 284,419	160	$ 1,559,346	$ 1,060,355	$ 498,991
Jun-15	73	$ 779,922	$ 530,347	$ 249,575	163	$ 1,496,718	$ 1,017,768	$ 478,950
	Total	$ 9,433,379	$ 6,414,698	$ 3,018,681	Total	$ 19,637,669	$ 13,353,615	$ 6,284,054
	Estimated Total Annual Payments for HCBS at 32% of Comparable RTC costs (average 241 children/youth)						$	9,302,735
	Estimated Total Annual Payments for RTCs at current cost for 94 youth (28% removed)[c]						$	11,739,096
	Estimated Total RTC and HCBS Costs						$	21,041,831
	Estimated Savings (Total RTC Costs $40,376,457[d] - $21,041,831)						$	19,334,626

Source: Division of Health Care and Financing Policy (DHCFP) Data Warehouse

Table notes:

Calculations based on PRTF Demontration Data (Average savings of 68% or waiver services only costing 32% of comparable services).

Number of youth calculated based on removing 28% from total (94 or 28% represents number of children and youth who may still require RTC services based on multiple RTC placements).

[a]Estimated net payment calculated by removing 28% (estimated amount x .72).

[b] Estimated savings (estimated net payment x .68).

[c]Estimated net payment divided by number of youth. Average Nevada RTC cost $11,093 (see Exhibit V) per month per youth + average OOS RTC cost $9,721 (see Exhibit V) per month per youth divided by 2 = $10,407 (average payment per month for 94 children/youth or 28%). $10,407 x 94 children/youth = $978,258. $978,258 x 12 months = $11,739,096 estimated annual payment for 94 children/youth.

[d]See appendix D.

The common theme across all states is that children and youth with the highest level of need benefited the most from participating in the demonstration. These participants showed the most improvement in the following areas:

- Decreased juvenile justice involvement;
- Increased school functioning;
- Decreased alcohol and other drug use; and
- Increased social support.[13]

[13] Report to the President and Congress - Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities (as required by the Deficit Reduction Act of 2005 P.L. 109-171).

Children's Mental Health Initiative (CMHI)

The federally funded CMHI was designed to develop more available HCBS for children and youth affected by serious emotional disorders. The CMHI involved the provision of a broad array of community-based services and supports to children, youth, and their families that enabled the children and youth to stay in their homes and communities. Exhibit VIII summarizes the outcomes and reduced costs associated with implementing the CMHI.

Exhibit VIII

Improved Youth Outcomes

Outcomes	Reduced Costs Based on Federal Study of Over 9000 Youth (between 2006 - 2013)
Hospitalizations decreased by 42%	More than $37 million
Emergency room visits decreased by 75%	Nearly $15 million
Suicide attempts decreased by 64%	
Juvenile arrests decreased by 38%	$10.6 million
Decrease in clinical symptoms for 40% of children	
Only 6.3% of youth repeated a grade compared to 9.6% of general public students	Potential savings of $3.3 million
School dropouts decreased by 11%	Over $380 million when extrapolated to all youth enrolled
Caregiver employment increased by 21%	Reduction of $10,171 in average cost of unemployment per caregiver

Table note:
Data based on 9,244 children and youth aged 14 to 18 enrolled in CMHI.

In addition to traditional services, such as individual and family therapy and medication management, the PRTF demonstration program and CMHI core benefit package included a number of other home and community-based services:

- Intensive care coordination (often called wraparound service planning/facilitation);
- Family and youth peer support services;
- Intensive in-home services;
- Respite care;
- Mobile crisis response and stabilization; and
- Flex funds (customized goods and services).

Many states developed programs with the help of federal funds to improve outcomes for children and youth with serious emotional disorders, including the

PRTF demonstration program and CMHI. These programs helped keep children and youth in family and community settings and reduced RTC placements.

DCFS WIN Services Are an Example of Successful HCBS Strategies

DCFS provides Wraparound in Nevada (WIN) services, which is nationally recognized by the federal government as a "promising practice" program.[14] The limited program provides intensive community-based services for children and youth with SED and who are in the custody of the state or county child welfare system. The WIN program has served 2,060 children and youth since July 1, 2010. The average length of services for children, youth, and families is nine and half months. Exhibit IX lists some of the improved outcomes from the WIN program's intensive HCBS strategies.

Exhibit IX

Improved Outcomes from Intensive HCBS Strategies
Fiscal Year 2015

Outcomes	Decrease
Arrests	17%
School suspensions/expulsions	16%
School absences	28%

Source: DCFS

The development of more HCBS strategies in Nevada for children and youth with serious emotional disorders would move to a lower utilization of residential treatment services, may improve outcomes, and could lower costs.

Recommendation

1. Transition from residential treatment center (RTC) placements to home and community-based services (HCBS) strategies.

Exhibit X

Estimated Benefits

Recommendation	Annual Benefit
1. Transition from RTC placements to HCBS strategies.	Over $19 million

[14] The WIN program is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services.

Modify Medicaid State Plan

DCFS should modify the Medicaid state plan by developing new benefit designs and redesigning existing benefits. This will increase HCBS billable services, reduce spending, and improve outcomes for children and youth with SED.

Develop New Benefit Designs in the Medicaid State Plan

Developing new benefit designs will help transition from RTC placements to more cost effective HCBS that show improved outcomes for children and youth. The Medicaid state plan currently includes many but not all billable services the Centers for Medicare and Medicaid Services (CMS) may approve for HCBS strategies.

The following behavioral health outpatient services are authorized and reimbursable through the Medicaid state plan:

- Assessment and diagnosis;
- Testing;
- Basic medical and therapeutic services;
- Crisis intervention;
- Therapy;
- Partial and intensive outpatient hospitalization;
- Medication management; and
- Case management services.

Surveys of other states' Medicaid state plans show reimbursable services, such as:

- Wraparound facilitation;
- Intensive in-home services;
- Respite;
- Habilitation;
- In-home residential supports;
- Training and support for unpaid caregivers;
- Co-occurring services;
- Nursing services;
- Family care coordination;
- Expressive and experiential behavioral services; and
- Non-medical transportation.

There are more reimbursable services available to include in the Medicaid state plan that could improve the outcomes for children and youth.[15]

Redesigned Benefits May Reduce Overall Medicaid Spending

The Medicaid state plan can be redesigned to improve outcomes for children and youth with SED and their families and could reduce spending. The state can design HCBS that offer an array of strategies to meet the multiple and changing needs of children and youth at potentially lower costs.

CMS authorizes states the flexibility to design benefits for target populations within each state's Medicaid state plan. Surveys of other states show three state plan options that could be designed specifically for children and youth with SED include: the 1915(i) State Plan Home and Community Bases Services; 1915(c) Home and Community Based Waivers; and the Health Home State Plan Option.

1915 (i) State Plan Home and Community-Based Services

CMS allows states to offer a variety of services under the Medicaid state plan HCBS benefit. Medicaid members must meet state-defined criteria based on need and typically get a combination of acute-care medical and long-term services. 1915(i) State Plan HCBS options include:

- Target the HCBS benefit to one or more specific populations;
- Establish separate additional needs-based criteria for individual HCBS;
- Establish a new Medicaid eligibility group for people who get state plan HCBS;
- Define the HCBS included in the benefit, including state-defined and CMS approved "other services" applicable to the population; and
- Option to allow any or all HCBS to be self-directed.

[15]See Appendix E for additional reimbursable services.

1915(c) Home and Community-Based Services Waivers

States can develop waivers to expand the array of home and community-based services and supports for target populations that promote community living with a view towards improving outcomes and reducing costs. The HCBS waiver permits states to have flexibility in designing benefits, including the latitude to:

- Determine target group;
- Determine geographic areas of the state;
- Apply institutional income and resource eligibility rules; and
- Specify the services.

Health Home State Plan Option[16]

The Affordable Care Act of 2010, Section 2703 added Section 1945 of the Social Security Act that created an optional Medicaid state plan benefit for states to establish health homes to coordinate care for people with Medicaid who have chronic conditions.[17] The health home provision provides an opportunity to build a person-centered system of care[18] designed to achieve improved outcomes for enrollees and ensure care and value for state Medicaid programs.[19] The health home state plan option allows states the flexibility to:

- Target health home enrollment by condition;
- Target health home services geographically;
- Determine eligible health home providers; and
- Design their payment methodologies and may propose alternatives.

States implementing health homes receive enhanced federal funding (90 percent federal match) for the first eight fiscal quarters from the effective date of the state plan amendment for health home services. After that, services are matched at the state's usual rate.[20]

Twenty-seven states[21] are using the Medicaid state plan and waiver options to target services for the SED population using an array of HCBS in an attempt to improve outcomes for children and youth and reduce spending.[22] Federal studies

[16] Health homes operate under a "whole-person" philosophy. This philosophy is educational, focused on disease prevention and, to the extent possible, fully engages the participation of individuals in their health recovery process.
[17] Chronic conditions include mental health, substance abuse, asthma, diabetes, heart disease, and obesity.
[18] Person-centered system of care supports active involvement of patients and their families in decision making about individual options for treatment and in the design of new care models.
[19] The provision supports CMS's overarching objective of improving health care through the simultaneous pursuit of three goals: 1) Improve the experience of care 2) Improve the health of populations 3) Reduce per-capita costs of health care.
[20] Nevada's federal medical assistance percentage (FMAP) for Medicaid is 64.67%.
[21] See Appendix F.
[22] See Appendix E.

have shown these services reduce the need for higher levels of care, improve youth outcomes, and reduce spending.

Modifying the Medicaid state plan by developing new benefit designs and redesigning existing benefits will increase HCBS billable services, reduce spending, and improve outcomes for children and youth with SED.

Recommendation

2. Modify the Medicaid state plan to develop new benefits and redesign existing benefits for children and youth with serious emotional disorders.

Appendix A

Division of Child and Family Services
Response and Implementation Plan

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Governor

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June 6, 2016

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Mr. Weinberger,

This letter is to update the Executive Branch Audit Committee regarding The Division of Child and Family Services (DCFS), Children's Mental Health audit. The Division appreciates the opportunity to receive feedback regarding current operations.

Recommendation No. 1
Transition from residential treatment center (RTC) placements to home and community-based services (HCBS) strategies.

Response: DCFS accepts this recommendation. This recommendation is the first goal in the Substance Abuse and Mental Health Services Agency (SAMHSA) System of Care Implementation grant that DCFS received in October 2015. DCFS has a strategic action plan for each of the four goals in this grant. The first goal is to increase access to community based services for children and families, therefore reducing reliance on residential treatment services. The action plan was developed with the Children's Mental Health Consortia in all three regions of the State (Clark, Washoe, and Rural). Although this is a four year grant, the action plan includes several first steps to begin meeting this recommendation. For example, DCFS has formed a workgroup to address out of state placements and develop more organized policy and procedures regarding the use and reliance on out of state placements. This step of the action plan will be completed by September 30, 2017. DCFS is also in the process of recruiting community based providers and developing an infrastructure that will ensure community based providers use evidence based quality services so that children are getting healthier and reaching expected outcomes when they have access to the appropriate level of service. It is expected this recommendation will be fully implemented at the end of the four year grant, or by September 2019.

Recommendation No. 2
Modify the Medicaid state plan to develop new benefits and redesign existing benefits for children and youth with serious emotional disorders.

Response: This recommendation is accepted. This recommendation is also a part of the SAMHSA System of Care Implementation Grant Strategic Action Plan. DCFS, in partnership with the Division of Health Care Financing and Policy (who administers the State Medicaid Plan), are working with community stakeholders and researching the best option for Nevada. The work done by the Executive Branch Audit Division has been helpful to this research. It is expected that this action step will be completed by September 30, 2019 (the end of the grant period).

The Division appreciates the opportunity to improve services for Nevada's Children and Families. If you have any further questions regarding this information please feel free to contact me at 775-684-4559.

Sincerely,

Kelly C. Wooldridge, LCSW
Administrator, DCFS

CC: Warren Lowman, Executive Bran Audit Manager
Richard Whitely, Director, Department of Health and Human Services

Appendix B

Timetable for Implementing Audit Recommendations

In consultation with the Department of Health and Human Services and the Division of Child and Family Services, the Division of Internal Audits categorized the six recommendations contained within this report into two separate implementation time frames (i.e., *Category 1* – less than six months; *Category 2* – more than six months). The department and division should begin taking steps to implement all recommendations as soon as possible. The department's and division's target completion dates are incorporated from Appendix A.

Category 2: Recommendations with an anticipated implementation period exceeding six months.

Recommendations	Time Frame
1. Transition from residential treatment center (RTC) placements to home and community-based services (HCBS) strategies. (page 14)	Sep 2019
2. Modify the Medicaid state plan to develop new benefits and redesign existing benefits for children and youth with serious emotional disorders. (page 18)	Sep 2019

The Division of Internal Audits shall evaluate the action taken by the division concerning report recommendations within six months from the issuance of this report. The Division of Internal Audits must report the results of its evaluation to the committee and the department.

Appendix C

Analysis of Mental/Behavioral Health Services Paid in Fiscal Year 2015

Total medicaid members	487,586
Behavioral health (BH) members	30,278
Average number of BH children and youth members receiving RTC services[a]	330
Percent of BH members to total Medicaid members	6%
Percent of BH RTC children and youth to total BH members[b]	1%
Total amount paid for all BH services	$191,296,012
Average BH services cost paid per BH member	$6,318
Combined net BH payment (in-state/out-of-state) for RTC services[c]	$40,376,457
Percentage of cost children and youth RTC servcies represents in comparison to total BH services paid[d]	21%

Source: Division of Health Care Financing and Policy (DHCFP)

Table notes:

[a] Total children and youth (July 1, 2014 - June 30, 2015) divided by 12.

[b] 330 divided by 30,278.

[c] Total NV RTC net payment plus total OOS RTC net payment.

[d] $40,376,457 divided by $191,296,012.

Appendix D

Nevada and OOS RTC Breakdown of Costs for Fiscal Year 2015

	Nevada Residential Treatment Centers			Out-of-State Residential Treatment Centers		
	Number of Youth	Net Payment	Average Monthly Net Payment per Youth	Number of Youth	Net Payment	Average Monthly Net Payment per Youth
Jul-14	97	$ 1,091,116	$ 11,249	243	$ 2,404,081	$ 9,893
Aug-14	91	$ 1,047,439	$ 11,510	249	$ 2,367,893	$ 9,510
Sep-14	80	$ 902,856	$ 11,286	233	$ 2,297,854	$ 9,862
Oct-14	88	$ 976,660	$ 11,098	248	$ 2,436,797	$ 9,826
Nov-14	96	$ 1,062,977	$ 11,073	243	$ 2,389,709	$ 9,834
Dec-14	98	$ 1,117,033	$ 11,398	234	$ 2,366,093	$ 10,112
Jan-15	103	$ 1,188,314	$ 11,537	224	$ 2,277,212	$ 10,166
Feb-15	102	$ 1,080,297	$ 10,591	225	$ 2,020,607	$ 8,980
Mar-15	104	$ 1,181,187	$ 11,358	229	$ 2,284,833	$ 9,977
Apr-15	114	$ 1,136,354	$ 9,968	228	$ 2,184,928	$ 9,583
May-15	109	$ 1,234,457	$ 11,325	222	$ 2,165,759	$ 9,756
Jun-15	101	$ 1,083,225	$ 10,725	227	$ 2,078,775	$ 9,158
Average		$ 1,091,826	$ 11,093		$ 2,272,879	$ 9,721
	Total	$ 13,101,915		Total	$ 27,274,542	
	Combined Annual Net Payment					$40,376,457

Source: Division of Health Care and Financing Policy (DHCFP) Data Warehouse

Table note:

Average total number of youth in RTC placements each month is 332.

Appendix E

Examples of Services for SED Population Provided Through Medicaid State Plans - 1915(i), 1915(c), and Health Homes

	Home and Community-Based Services 1915(i)	Home and Community-Based Services 1915(c)	Health Homes
Examples of Services Provided for SED Population:	*Wraparound facilitation *Intensive in-home services *Habilitation *Respite (in and out of home) *Training and support for unpaid caregivers *Consultative clinical and therapeutic services *Education and support services *Family support specialist *In-home therapy *Non-medical transportation *Family peer support *Co-occurring services *Specialized evaluation services *Crisis intervention services *Redirection services *Expressive & experiential behavioral services (art, dance, drama, music, equine, horticultural) * Customized goods and services	*Respite *Habilitation *Crisis stabilization *In-home residential supports *Consumer education and training *Family care coordination *Attendance care *Behavioral assistance/intense behavioral intervention services *Training and support for unpaid caregivers *Non-medical transportation *Medication monitoring and wellness education *Skill building services *Wraparound facilitation *Therapeutic overnight camping *Vocational services *Nursing services *Daily living skills training *Community transition services	*Comprehensive care management *Care coordination *Health coordination *Comprehensive transitional care and follow-up *Individual and family supports *Referral to community and social support services

Source: Medicaid

Appendix F

States Using Medicaid State Plans - 1915(i), 1915(c), and Health Homes to Target Services for SED Population

State	1915(i) State Plan	1915(c) Waiver	Health Home
Alabama			x
Alaska		x•	
District of Columbia			x
Florida	x		
Georgia		x•	
Idaho			x
Indiana	x	x•	
Iowa		x	x
Kansas		x•	x
Louisiana		x	
Maine			x
Maryland	x	x•	x
Michigan		x	x
Mississippi		x•	
Missouri			x
Montana	x	x•	
Nevada	x[a]	x [b]	
New Jersey			x
New York[c]		x	x
Ohio			x
Oklahoma			x
Rhode Island			x
South Carolina		x•	
South Dakota			x
Texas		x	
Virginia		x•	
Wisconsin		x	
Wyoming		x	

Source: Medicaid

Table notes:

• States that participated in PRTF five-year demonstration grant and used the 1915(c) waiver authority

[a] NV 1915(i) services includes adult day health care, habilitation, day treatment or other partial hospitalization services. DHCFP data does not show any habilitation services billed in FY 15 through November 2015.

[b] NV 1915(c) waivers are specific to persons with physical disabilities; persons with intellectual disabilities and related conditions; and frail elderly.

[c] 1915(c) Waiver expired 12/31/15.