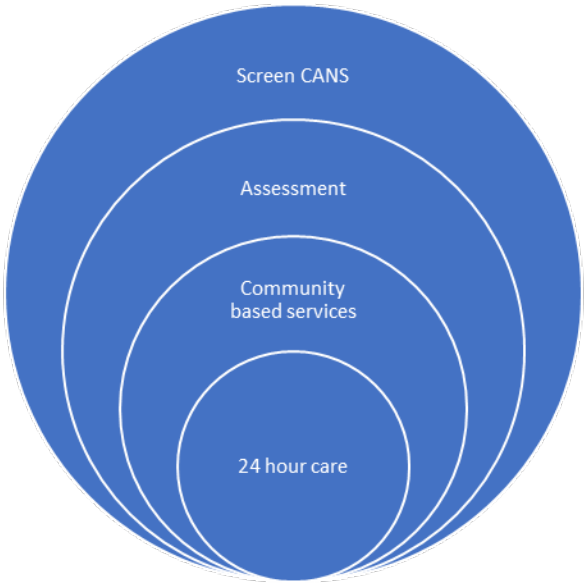
Implementation Target 2.1

To assess need, HSD and CYFD will define initial expected service utilization for screening/assessment, High Fidelity Wraparound services, evidence-based, well-supported, or promising therapeutic treatment for children with complex trauma, intensive case management, mobile crisis response services and intensive home-based services. The Co Neutrals must approve the methodology for predicting expected utilization of these services.

"… evidence-based, well-supported, and promising trauma-responsive services, which include intensive case management, High Fidelity Wraparound services, intensive home-based services, and trauma-based therapies including Dialectical Behavior Therapy (DBT), Multi-Systemic Therapy (MST), trauma-informed Cognitive Behavioral Therapy (CBT), Functional Family Training (FFT), and Eye Movement Desensitization and Reprocessing therapy (EMDR)."

Introduction

The cross-departmental utilization workgroup is tasked with projecting service utilization of evidenced-based practices (EBPs) and other assessment and trauma related services for a base population of New Mexico youth and adolescents in CYFD custody. The method of study outlines four steps in this process. In chronological order the services begin with the Child and Adolescent Needs and Strengths Screen for all CISC (Target 100%), and includes assessment and referral to outpatient services, managed care coordination, and the identification of children who require 24-hour care for stabilization and or treatment.



High Level Summary of Steps

Step 1: Identify the current state of service utilization for the children in state custody (CISC) as reported in calendar year 2019 Medicaid and other state funded data, i.e. Home and Community Based Services Waiver (HCBS services), Individualized Education Plan (IEP) services, non-Medicaid services by state general or federal funding sources through CYFD, care coordination through the Managed Care Organizations and CareLink New Mexico Health Homes (CLNM), and the Child and Adolescent Needs and Strengths (CANS) screen.

Step 2: Compare NM service provision with the second National Survey of Child and Adolescent Well-Being (NSCAW II) which is specific to children having encountered the child welfare system. The NSCAW II study is sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS). (Appendix 1) The study is longitudinal and examines the functioning, service needs, and service use of children who come in contact with the child welfare system. The study cohort included 5,873 children involved with child welfare ranging from birth to 18 years of age across 83 counties nationwide. For purposes of this deliverable, we draw from the mental health/behavioral health aspects of the NSCAW II study, which is both descriptive and predictive in scope.

Step 3: Identify qualifying considerations in projecting, assessing, tracking, and adjusting the future utilization of selected EBP services. The State will use the Child and Adolescent Needs and Strengths (CANS) screen and its built-in decision-making tools to identify which members of the CISC cohort would benefit from a comprehensive behavioral health assessment which includes a diagnostic evaluation. On December 1, 2021, the Crisis Assessment Tool (CAT) and the CANS were implemented for all CISC. This step will also examine the evidence for use of each of the selected trauma-based therapies. The State is also working with Mercer, our actuarial firm, in projecting service utilization for rate development. Semi-annual claims for Medicaid and non-Medicaid services will be compiled by the Data Validation Team and reviewed by the Utilization team and our actuarial consultants.

Step 4: Survey the New Mexico behavioral health providers and practitioners to determine both capacity and interest in pursuing the evidence-based practices through a State sponsored/funded training and certification roll-out. Establish a process to track and incentivize participating practitioners. Educate our Managed Care Organizations on the effort and recruit qualified practitioners and provider organizations.

The four-step methodology is described below, as well as future steps in the analysis and implementation of training.

Step 1: Description of CISC cohort and utilization of behavioral health services

Table (1) describes the CISC cohort for CY 2019 in terms of age, race/ethnicity, and placement/setting. The cohort consists of 3,880 youth between birth and 18 years of age. There were 1,709 children between the ages of 0 and 5; 1,027 children between 6 and 10 years old; and 1,144 youth between the ages of 11 and 18. Relative to age, the cohort is evenly distributed. In relation to race/ethnicity the cohort is predominantly Hispanic (60.9%), compared to other race/ethnicity classifications. The placement/setting categories identify 362 children in congregate care settings (Community Homes, Group Homes, Shelter, and Residential Treatment), and 335 children in Treatment Foster Care. Together these categories identify 18% of the CISC population had 24-hour care, either clinical or non-clinical. The State has made progress in placements involving relatives, nonetheless 780 CISC lived with relatives in foster care and 1,865 lived in non-relative foster care settings.

Table 1: CISC by age, race/ethnicity and placement/setting for 2019

	Data from 2019 baseline Cohort (FACTS)	N
Total		**3880**
Age (years)		
	0 through 2	**977**
	3 through 5	**732**
	6 through 10	**1027**
	11 through 18	**1144**
Race/Ethnicity		
	Hispanic	**2363**
	NH American Indian or Alaska Native	**265**
	NH Black	**199**
	NH Multi-race	**102**
	NH White	**894**
	NH Other	**57**
Placement/Setting		
	Community Home	**21**
	Residential Facility, accredited & non-accredited	**186**
	Group Home, Shelter, Maternity Home	**155**
	Non-TFC Foster Family Home (Non-Relative)	**1865**
	Non-TFC Foster Family Home (Relative)	**780**
	Pre-Adoptive Family	**155**
	Runaway/Missing	**63**
	Supervised Independent Living	**8**
	TFC Foster Family Home (Non-Relative)	**325**
	TFC Foster Family Home (Relative)	**10**
	Trial Home Visit	**312**

Table (2.0) describes the CISC cohort in relation to the County where the case originated, and in relation to the source of funds for services billed in CY 2019. The 'STAR' column represents reimbursement for non-Medicaid services or Medicaid services provided to individuals not eligible for Medicaid. High-fidelity Wraparound utilization is in the column titled 'HFW.' Altogether, 3,125 children were identified as BH service recipients in CY 2019, accounting for 80.5% of the CISC cohort. Medicaid was the source of funding in 99.2% of the case counts. The distribution of case counts is widely dispersed across counties. Counties are classified as urban, rural, or frontier and indicate 45.3% of the cases originated in urban counties, 44.8% in rural counties, and 9.9% in frontier counties.

Table 2.0: CISC by Age, County and funding source for 2019

Case County	County Type	Program			Grand Total
		Medicaid	STAR	HFW File	
Bernalillo	Urban	1,147	93	40	1,159
Catron	Frontier	2			2
Chaves	Rural	158	14	4	159
Cibola	Frontier	49	2	1	49
Colfax	Frontier	22	1		22
Curry	Rural	100	11	8	100
DeBaca	Frontier	15	1	1	15
Dona Ana	Urban	255	15	1	255
Eddy	Rural	124	11	2	124
Grant	Rural	59	1		60
Guadalupe	Frontier	8			8
Hidalgo	Frontier	2	1		2
Lea	Rural	173	17	15	173
Lincoln	Frontier	27	1		27
Los Alamos	Urban	2			2
Luna	Rural	30	1		30
McKinley	Rural	49	2	1	49
Mora	Frontier	9			9
Otero	Rural	96	8		97
Out of State		2	1		2
Quay	Frontier	6			6
Rio Arriba	Rural	85	10		88
Roosevelt	Rural	11		2	11
San Juan	Rural	145	19	4	149
San Miguel	Frontier	82	12	2	82
Sandoval	Rural	57	5	2	57
Santa Fe	Rural	117	14	1	118
Sierra	Frontier	12			12
Socorro	Frontier	27	1		27
Taos	Rural	51	4		52
Torrance	Frontier	46	5	1	46
Union	Frontier	1			1
Valencia	Rural	132	8	1	132
Grand Total		**3,101**	**258**	**86**	**3,125**

† Duplication may occur where a service was rendered between one or more programs. The total is the unduplicated persons served.

Table (2.1) describes service utilization for the 2019 Medicaid enrolled CISC population across 34 basic Medicaid categories of service. The Table reports counts of individuals using services, the percent of the population using services, and their rank. The 34 basic Medicaid service categories can be further differentiated through 222 different service descriptions, 25 UB revenue codes, 177 CPT/HCP codes and 2,271 diagnosis criteria. These informational considerations offer a comprehensive snapshot of service utilization in CY 2019.

Table (2.1): Service Utilization Arranged by Program Category, Number of Clients, Percent-Served and Rank

Medicaid Category	Distinct Count of Person ID (n=3,101)	% Srvd	Rank
Screening & EPSDT periodocity	2548	82%	1
Assessment, psych eval	1552	50%	2
Case management	1549	50%	3
FFT & family therapy	1388	45%	4
Over 60 min BH terapies	1060	34%	5
45 min BH therapies	918	30%	6
30 min BH therapies	877	28%	7
30 min E & M	776	25%	8
School based	483	16%	9
Treatment foster care	402	13%	10
Services for each	358	12%	11
Group therapies	318	10%	12
Emergency Dept	280	9%	13
Inpatient	247	8%	14
Residential & youth shelter	225	7%	15
PH & Day Treatment	198	6%	16
CCSS	181	6%	17
Treatment Planning	133	4%	18
High-Fidelity Wraparound	132	4%	19
Crisis triage, clinic & mobile	122	4%	20
60 min BH therapies	104	3%	21
15 min E & M	74	2%	22
Brief intervention & 15 min therapies	61	2%	23
45 min E & M	59	2%	24
CLNM Health Homes	49	2%	25
Medication assisted treatment	42	1%	26
Multi-systemic therapy (MST)	35	1%	27
Over 60 min E & M	32	1%	28
Applied Behavior Analysis (ABA)	25	1%	29
BMS	23	1%	30
60 min E & M	21	1%	31
IOP, ACT	5	0%	32
Care Coordination	3	0%	33
Urgent care	1	0%	34
Distinct Totals	**3,101**		

Table (2.1): Continued			
HFW Category	**Distinct Count of Person ID (n=86)**	**% Srvd**	
High-Fidelity Wraparound	86	100%	
STAR Category	**Distinct Count of Person ID (n=258)**	**% Srvd**	**Rank**
Case management	172	67%	1
Non clinical congregate care	68	26%	2
Secondary prevention	35	14%	3
Group therapies	23	9%	4
Residential & youth shelter	16	6%	5
Assessment, psych eval	12	5%	6
FFT & family therapy	9	3%	7
Treatment Planning	9	3%	7
Brief intervention & 15 min therapies	8	3%	9
Non-clinical congregate care	8	3%	9
30 min BH therapies	6	2%	11
45 min BH therapies	6	2%	11
Over 60 min BH terapies	6	2%	11
CCSS	5	2%	14
Medication assisted treatment	1	0%	15
Distinct Totals	**258**		

Table (2.2) extends the summary of 34 basic Medicaid service categories to include distinct counts of billing providers reported in the encounter claim information. The Table identifies 790 distinct billing providers across 34 BH service categories (approximately 25 may be duplicated, reflecting multiple payor sources).

Table (2.2): Service Provision by Program Category, Number of Clients and Providers and Rank (clients served)			
Medicaid Category	**Distinct Count PersonID**	**Distinct Count ProviderID**	**Rank (Clients Served)**
Screening & EPSDT periodocity	2,548	148	1
Assessment, psych eval	1,552	298	2
Case management	1,549	51	3
FFT & family therapy	1,388	209	4
Over 60 min BH terapies	1,060	271	5
45 min BH therapies	918	169	6
30 min BH therapies	877	153	7
30 min E & M	776	117	8
School based	483	82	9
Treatment foster care	402	9	10
Services for each	358	48	11
Group therapies	318	58	12
Emergency Dept	280	30	13
Inpatient	247	41	14
Residential & youth shelter	225	39	15
PH & Day Treatment	198	47	16
CCSS	181	26	17

Table (2.2): Continued			
Medicaid Category	**Distinct Count PersonID**	**Distinct Count ProviderID**	**Rank (Clients Served)**
Treatment Planning	133	12	18
High-Fidelity Wraparound	132	5	19
Crisis triage, clinic & mobile	122	32	20
60 min BH therapies	104	14	21
15 min E & M	74	22	22
Brief intervention & 15 min therapies	61	29	23
45 min E & M	59	27	24
CLNM Health Homes	49	9	25
Medication assisted treatment	42	6	26
Multi-systemic therapy (MST)	35	6	27
Over 60 min E & M	32	9	28
Applied Behavior Analysis (ABA)	25	9	29
BMS	23	7	30
60 min E & M	21	8	31
IOP, ACT	5	3	32
Care Coordination	3	2	33
Urgent care	1	1	34
Distinct Totals	**3,101**	**764**	
HFW Category	**stinct Count Person ID (n=8**	**Distinct Count ProviderID**	**Rank (Clients Served)**
High-Fidelity Wraparound	86	1	1
STAR Category	**stinct Count PersonID (n=25**	**stinct Count ProviderID (n=7**	**Rank (Clients Served)**
Case management	172	9	1
Non clinical congregate care	68	9	2
Secondary prevention	35	8	3
Group therapies	23	7	4
Residential & youth shelter	16	3	5
Assessment, psych eval	12	6	6
FFT & family therapy	9	6	7
Treatment Planning	9	6	7
Brief intervention & 15 min therapies	8	5	9
Non-clinical congregate care	8	5	9
30 min BH therapies	6	4	11
45 min BH therapies	6	2	11
Over 60 min BH terapies	6	3	11
CCSS	5	3	14
Medication assisted treatment	1	1	15
Distinct Totals	**258**	**25**	

Table 2.2 shows that there are 796 providers (approximately 25 may be duplicated due to being counted in different payor sources). High-Fidelity Wraparound shows as 1 provider, however there are now 10 providers, thus this will be adjusted in future data pulls. HFW is currently tracked using smart sheets but will be tracked primarily in the Medicaid Management Information System (MMIS) using encounter data once the Centers for Medicaid and Medicare Services (CMS) approves the State's 1115 waiver amendment for HFW and the new rates are effective. Smart sheets will still be required initially as we

develop access for the CYFD in the MMIS. Smart Sheets is monitored by CYFD BHS Wraparound Team currently.

A breakout of Protective Services CYFD funded services for CISC are outlined in **Table 3**.

Table 3: CYFD funded services			
Services for Children/Youth in Fo	*Description*	*Target Pop*	*$ Source*
Time Limited Reunification Services	Case management, visitation, safety practice for child+ family to support reunification under 15 months from time of removal.	Children & Families in Custody	FF/GF
Reunification Services	Case management, visitation, safety practice for child+ family to support reunification under 15 months from time of removal.	Children & Families in Custody	FF/GF
Child Advocacy Centers	Forensic Interview, SANE, advocacy	Children in Custody or Not in custody	GF
Transitional Living for Young Adults	Housing, Case management, life skills 16.5-18years old into adulthood	Youth in custody, youth aged out or in JJ or at risk	FF/GF
Keeping Families Together	Housing, Case management, housing, parenting	Children & Families in custody reunifying	FF (TANF)
Kinship Navigator	Case management, peer to peer groups, connection to other services	Children & Relatives in custody or Not in custody	FF/GF
PS Crisis Bed Services	Emergency crisis stabilization placement	children in custody	GF
Host Homes Pilot	Host Home model of housing for 15-18yo	children in custody	FF (TANF)

The information in **Appendix 2** will serve as the master list of BH services reimbursed through Medicaid and other funding sources. It will be used for a descriptive analysis in the determination of utilization by CISCs. Appendix 2, Summary Tab, details services by categories which are based upon levels of care, from screening and assessment through brief interventions, outpatient, intensive outpatient to residential and foster care, and finally urgent care, emergency, and inpatient care. Data are broken out by county for every category of service. Also listed is the number of providers delivering these services within each county, and how many children have received that service within the county. The current Appendix 2 shows the county of origin of the CISC (where they lived when placed in custody). Some of the services that are part of our agreement which can be distinguished through claims have their own category, i.e., screening and assessment, high-fidelity wraparound, crisis services, and CLNM health homes which include intensive care coordination. General therapy and evaluation and management codes are categorized by increments of billable units, i.e., 15 minutes, 30 minutes, 45 minutes, 60 minutes or more. Other therapies are billed as “each” such as psych testing,

neurobehavioral testing, and activity therapy. For those categories which may be comprised of physical health as well as behavioral health such as inpatient, we delineated behavioral health by requiring a behavioral health diagnosis.

The Service Categories Tab of Appendix 2 defines each code within a category and whether it requires a behavioral health diagnosis. The Diagnostics Tab of Appendix 2 includes a list of the diagnoses used to bill for behavioral health services.

Step 2: Comparison of New Mexico data with NSCAW II: targets and projections

In the NSCAW II study, Caregivers were asked if "your child received any service for emotional, behavioral, learning, attentional, or substance abuse problems in the past 12 months or since the start of the child's living arrangement". This was used to identify the services children received. Screens were applied to the cohort to determine risk or behavioral need. The prevalence of risk of a behavioral/emotional problem among children 1.5 to 17 years old overall was 41.4%, which means in need of behavioral health services. *The prevalence of risk of a behavioral/emotional problem or substance abuse problem specifically among children 11 - 17 years old was 60.9% (57.2% had a risk of a behavioral/emotional problem, 19.3% had a risk of a substance abuse problem). For age group 6-10, 49.5% of children had a risk, and for children age 1-5, 20.5% demonstrated a need/risk for behavioral health services.* **(Table 4)**

Table 4: NSCAW 11 Study "risk of behavioral/emotional problem" Predictive using screens

Exhibit IV-10. Risk of a Behavioral/Emotional Problem Among Children 1.5 to 17 Years Old

		Risk of a behavioral/emotional problem [a]	
	N	%	*SE*
Total	3,451	41.4	1.8
Gender			
Male	1,772	43.0	2.4
Female	1,679	39.7	2.1
Age (years)		****	
1.5–5	1,352	20.5 [b]	1.9
6–10	1,049	49.5 [c]	2.4
11–17	1,050	57.2	3.3
Race/ethnicity			
Black	980	38.6	2.5
White	1,317	43.4	2.5
Hispanic	891	40.6	3.4
Other	257	43.5	6.0
Setting			
In-home	2,359	40.9	2.0
Formal kin care	257	35.6	7.8
Informal kin care	286	46.6	5.4
Foster care	467	42.7	4.0
Group home or residential program	64	61.2	12.0
Insurance status			
Private	435	44.3	3.9
Public [d]	2,670	40.5	2.2
Other	87	51.6	10.3
Uninsured	229	40.1	4.5

Included in the study was the use of psychotropic medications which were found to be more prevalent in group homes than family homes. Also, interesting was that 33.3% of children birth to 5 years old had a score across measures indicating some developmental problem. Of those, only 13.1% had an Individualized Education Plan (IEP) or other related services.

Table 5 compares the age distributions of the study population (NM CISC) and national sample of children at risk for behavioral health by age group (NSCAW II).

Table 5: Age distributions of NM Study population and National Sample			
Age	NM CISC number	NSCAW II % of risk	NM CISC # at risk of behavioral/emotional problem
0-5	1709	20.5%	350
6-10	1144	49.5%	566
11-17	1027	60.9%	625

Step 3 Identify qualifying considerations in projecting the future utilization of EBP services.

The State has worked with Dr. Lyons and Dr. Fernando from the Praed Institute to create decision making tools, or algorithms, that will pull individual indicators from fields associated with symptoms, risk, needs, and strengths that are applicable to the EBP eligibility criteria. These algorithms will be used to inform clinical presentations of the cohort and allow the State to gauge how many children are likely to need which services. Comprehensive assessments together with diagnostic evaluations by qualified clinicians, when indicated, will further define the specific services that will be ordered. Further screening and re-assessments rendered every 6 months will clarify changing needs and progress, or not, towards the child-centered goals. It is important to note that children who scored 0 or 1, indicating no likely need of services, on their first screen will also be re-screened to determine any changing likelihood of need. Important, also, is following through each service with fidelity to better assure intended results, and not to interrupt a series of treatments by changing screening results.

New Mexico behavioral health policy https://www.hsd.state.nm.us/providers/behavioral-health-policy-and-billing-manual/ states "Culturally competent health care is achieved by identifying and understanding the needs and help- seeking behaviors of individuals and families (Goode, 2002). Practices are designed and implemented to match the unique needs of individuals, children, families, organizations, and communities served. Culturally competent systems of care are driven by consumer preferred choice, not by culturally blind or culture-free interventions." NM has a self-assessment checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs. Native American liaisons are part of state staff, with links to available Native Americans for educational staff needs so that screening and assessment tools are understood in the context of differing cultures, both Hispanic and Native American.

Table 6 delineates the ratings associated with likely needs. **Table 7** is the level 1 functional impairment criterion 1.1 (rates the behavioral health and emotional needs at a rating of 1) and functional impairment 2.1 (rates the behavioral health and emotional needs at a rating of 2 or 3). Functional impairment level 1 reflects a possible need that requires prevention and additional assessment. Level 2 reflects the need interferes with functioning and action or intervention is required. In the CANS portal this is 'flagged' as 'action required'.

Table 6: Rating scale for needs CANS

Rating	Level of Need	Appropriate Action
0	No evidence of need.	No action needed.
1	Significant history or possible need that is not interfering with functioning.	Watchful waiting / prevention / additional assessment.
2	Need interferes with functioning.	Action / Intervention required
3	Need is dangerous or disabling.	Immediate action / Intensive action required

Table 7: Functional Impairment Level 1

Treatment Need/Population Eligibility		
1	**Functional Impairment** **Prevention/Assessment** Criterion 1.1	**1.1** **At least one** rating of '1' on any of the Behavioral/Emotional Needs: – Psychosis – Impulsivity/Hyperactivity – Attention/Concentration – Depression – Anxiety – Oppositional – Conduct – Adjustment to Trauma – Anger Control – Substance Use – Eating Disturbance – Attachment Difficulties – Behavioral Regression – Somatization
2	**Functional Impairment** **Outpatient** Criterion 2.1	**2.1** **At least one** rating of '2', or '3' on any of the following Behavioral/Emotional Needs: – Psychosis – Impulsivity/Hyperactivity – Attention/Concentration – Depression – Anxiety – Oppositional – Conduct – Adjustment to Trauma – Anger Control – Substance Use – Eating Disturbance – Attachment Difficulties – Behavioral Regression – Somatization

Table 8 outlines functional impairment level 3 for Comprehensive Community Support Services (CCSS) which includes a rating of 2 or 3 in behavioral health/emotional needs; 2 or 3 in substance use; rating of 3 (complexity) in the life functioning domain; and rating of 2 or 3 in risk behaviors, or 3 items with a 1 or more.

Table 8: Functional Impairment level 3 (Comprehensive Community Support Services)

	Treatment Need/Population Eligibility		Complexity	
Functional Impairment 3 Community Support Services (Criterion 3.1 or Criterion 3.2) AND (Criterion 3.3 or Criterion 3.4)	**3.1**	**At least one** rating of '2' or '3' on any of the Behavioral/Emotional Needs: – Psychosis – Impulsivity – Hyperactivity – Atten/Concentration – Depression – Anxiety – Oppositional – Conduct – Adjustment to Trauma – Anger Control – Eating Disturbance – Attachment Difficulties – Behavioral Regression – Somatization	**3.3**	**At least one** rating of '3' on any of the Life Functioning items: – Family Functioning – Living Situation – Social Functioning – Recreational – Legal – Medical/Physical – Sexual Development – Sleep – School Attendance – School Behavior* – School Achievement* – Decision Making
	3.2	**At least one** rating of '2' or '3' on ***Substance Use*** AND **at least one** rating of '2' or '3' on any of the following Behavioral/ Emotional Needs: – Psychosis – Impulsivity/Hyperactivity – Atten/Concentration – Depression – Anxiety – Oppositional – Conduct – Adjustment to Trauma – Anger Control – Eating Disturbance – Attachment Difficulties – Behavioral Regression – Somatization	**3.4**	**At least one** rating of '2' or '3', OR **three or more** ratings of '1', '2', or '3' on any of the following Risk Behaviors: – Suicide – NSSI Behavior – Other Self-Harm – Danger to Others – Sexual Aggression – Delinquent Behavior – Runaway – Intentional Misbehavior – Fire Setting – Sexually Reactive Behavior – Victimization/Exploit.

Table 9 outlines the functional impairment level 4 for High-Fidelity Wraparound. The ratings include: a 3 on behavioral/emotional needs or 2 or more with a rating of 2 or 3;

two or more rating of 3 on life functioning (complexity) or three or more ratings 2 or 3; rating of 3 or two of more ratings of 2 or 3 on risk behavior domain; and at least one rating of 3 or two or more ratings of 2 or 3 on the caregiver resources and needs domain.

Referral to specialized EBP services requires a bio-psycho-social assessment by a qualified provider to determine eligibility. Grouping our cohort from zero (no need), level 1, level 2, level 3, and level 4 will assist the State in understanding the level of intensity needed. The providers will be trained in understanding how to use the information the CANS is communicating and will assist the alignment of language and understanding about trauma, needs, strengths through the child serving system of care.

Table 9: Functional impairment level 4: High-Fidelity Wraparound

	Treatment Need/Population Eligibility		Complexity	
Functional Impairment 4 Wraparound Criterion 4.1 AND (Criterion 4.2 OR Criterion 4.3) AND Criterion 4.4	**4.1**	**At least one** rating of '3', OR **two or more** ratings of '2' or '3' on any of the Behavioral/ Emotional Needs: – Psychosis – Impulsivity/Hyperactivity – Attention/Concentration – Depression – Anxiety – Oppositional – Conduct – Adjustment to Trauma – Anger Control – Substance Use – Eating Disturbance – Attachment Difficulties – Behavioral Regression – Somatization	**4.2**	**Two or more** ratings of '3', OR **three or more** ratings of '2' or '3' on any of the following Functioning items: – Family Functioning – Living Situation – Social Functioning – Recreational – Legal – Medical/Physical – Sexual Development – Sleep – School Attendance – Decision Making
			4.3	**At least one** rating of '3', OR **two or more** ratings of '2' or '3' on any of the following Risk Behaviors:

Table 10 outlines criteria unique to Dialectical Behavioral Therapy (DBT), Eye Movement Reprocessing and Desensitization (EMDR), and Trauma Focused Cognitive Behavioral Therapy (TFCBT).

Table 10: Evidence Based Practices: Dialectical Behavioral Therapy, EMDR, TF-CBT

		Treatment Need/Population Eligibility
Dialectical Behavioral Therapy Criterion 1 AND Criterion 2 AND Criterion 3 AND Criterion 4 AND Criterion 5	**1**	Child is at least 12 years old
	2	**A rating of '0'** on the Developmental/Intellectual item.
	3	**A rating** of '2' or '3' on Adjustment to Trauma and Interpersonal Behavior (for 16+), AND **a rating** of '2' or '3' on Impulsivity/Hyperactivity or Oppositional Behavior
	4	**At least two** ratings of '2' or '3' on the following Risk Behavior items: Suicide, NSSI Behavior, Intentional Misbehavior, Eating Disturbance
	5	**At least one** rating of '2' or '3' on Family Functioning or Social Functioning
Eye Movement Desensitization and Reprocessing	**1**	Child is at least 12 years old.

Criterion 1 AND Criterion 2	**2**	**A rating** of '2' or '3' on Adjustment to Trauma, Anxiety and Sleep
Trauma Focused-Cognitive Behavioral Therapy Criterion 1 AND Criterion 2 AND Criterion 3	**1**	Child is at least 5 years old.
	2	**A rating of '0'** on the Developmental/Intellectual item.
	3	**A rating** of '2', or '3' on Adjustment to Trauma, AND **at least one** rating of '1', '2' or '3' on any of the following Behavioral/Emotional Needs: - Impulsivity/Hyperactivity - Depression - Anxiety - Oppositional - Conduct - Anger Control - Interpersonal Problems (16+)

Finally, **Table 11** pulls out criteria related to Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Child Parent Psychotherapy (CPP). CPP was added to the EBP service array because 44% of the CISC are children in this age range.

Table 11: MST, FFT, CPP

	Treatment Need/Population Eligibility	
Multisystemic Therapy Criterion 1 AND (Criterion 2 or Criterion 3) AND Criterion 4	**1**	Child is at least 12 years old.
	2	**At least one rating of '3'** on any of the following items: – Delinquent Behavior – Danger to Others – Legal – Oppositional – Conduct – Substance Use
	3	**At least one** rating of '3', OR **two or more** ratings of '2' or '3' on any of the following items: – Delinquent Behavior – Danger to Others – Runaway – Legal – Oppositional – Conduct – Substance Use
	4	Child has a viable caregiver.
	1	Child is at least 11 years old.

Functional Family Therapy Criterion 1 AND Criterion 2 AND Criterion 3 AND Criterion 4	**2**	**A rating** of '2' or '3' on ***Substance Use*** AND **at least one** rating of '2' or '3' on any of the following Behavioral/ Emotional Needs: – Psychosis – Impulsivity/Hyperactivity – Attention/Concentration – Depression – Anxiety – Conduct – Adjustment to Trauma – Anger Control – Eating Disturbance – Attachment Difficulties – Behavioral Regression – Somatization
	3	**At least two ratings** of '2' or '3' on any of the following items: Oppositional, Intentional Misbehavior, Delinquent Behavior
	4	**At least two** ratings of '2' or '3' on any of the following Caregiver Resources and Needs items: Supervision, Knowledge, Involvement with Care
Child Parent Psychotherapy Criterion 1 AND Criterion 2 AND (Criterion 3 or Criterion 4)	**1**	Child is age birth thru 5 years old.
	2	**At least one** rating of 'Yes' on any of the Potentially Traumatic/Adverse Childhood Experiences.
	3	**At least one** rating of '2' or '3' on Adjustment to Trauma or Attachment Difficulties
	4	**A rating** of '2' or '3' on the Caregiver Post-traumatic Reactions item

Table 12 describes the future-state projection of EBP service users in three years and the implied penetration rates, that is, the number of users relative to the age-eligible populations. In the case of Mobile Crisis Teams, the workgroup projected service users based on state-level information for Georgia (SAMHSA, 2020). FFT national says FFT team with 3 therapists should see 43 families a year. In the case of Multisystemic Therapy (MST), the workgroup recognizes a current-state population of 49 "crossover" youth receiving MST services in Juvenile Justice and Protective services. The future-state is projected using the scaling factor applied in HSD's actuarial projection for High Fidelity Wraparound services **(Appendix 3**). For MST, FFT, and DBT which account for the 11 to 18 age group use the study's 61% target as at risk, divided among the three services.

Table 12: Future-State of Medicaid service utilization for the *Kevin S.* Cohort in CY 2023

Service Types and Crosswalk to Service Types	**Age range**	**CISC**	**Projected service users**	**Penetration Rate**
Child and Adolescent Needs and Strengths Screen (CANS)	All	Current number	All	100%

MCO Care Coordination[1][1]	All	3880	1940	50%
Assessment based on screening, est. from NSCAW 11 risk stats	All	3880	2367	61%
DBT: Dialectical Behavior Therapy	13 to 18	1,000	200	20%
EMDR: Eye Movement Desensitization	12 to 18	1027	205	20%
FFT: Functional Family Therapy, including Family Therapy/Educ./Training	10 to 18	1,030	309	30%
MST: Multisystemic Therapy,	11 to 18	1,027	205	20%
TF-CBT: Trauma-Focused Cognitive Behavior Therapy,	3 to 18	3,170	1,268	40%
High Fidelity Wraparound	0 to 18	3,880	776	20%
Intensive Care Coordination. (est. as sum of CLNM HH & CCSS)	0 to 18	3880	1590	41%

[1][1] This projection was made with an understanding that all CISC will be entering care on a Level 2 or 3 with the MCOs (requiring some level of care coordination) before being stepped down (which is able to happen as soon as appropriate and, in some cases, may be immediate). In the 1115 waiver renewal which will be submitted to CMS in late 2022, the State will coordinate with New Mexico tribes to submit a program change request that would increase this number significantly. Information about this proposal will be available in late Summer 2022. There are different penetration rates currently for care coordination, so as the shift occurs with CISC, we expect utilization to far exceed this 50% projection which was established taking into consideration the current baseline which is around 22% for CISC as well as current staffing ratios for Level 3 vs Level 2 care coordination.

Intensive home-based services/ CYFD	0 to 18	3880	583	15%
Child-parent psychotherapy	0 -5	1709	341	20%
Mobile response and stabilization services (est by Gordon, 2020)	0 to 21	3883	1,242	32%

Tables 1, 2.0, 2.1, and 2.2 above describe the CISC cohort in CY 2019 in terms of demographic characteristics, and their use of 34 categories of BH services. A predictive analysis of service utilization is provided in Table A(a) for 252 Native Americans in the CISC cohort. Table A reports the number of Native American children using each service category, the total number of times each service was used, and the average number of times each service was used. These measures are obtained for each category of service by matching encounter claim-counts to Billing provider ID. Projected CY 2022 service utilization applies a Poisson probability model, assuming 2.5% annual trend growth for service use and 5% annual population growth for the Native American CISC. These growth trends are in accordance with CY 2022 Medicaid rate development for CYFD children receiving BH services (Mercer BH CRCS, 2021). This utilization will not likely be impacted by increased access to Traditional services for Native and Tribal youth (App. C commitments), but rather would be complimentary to those services.

TABLE A: example of applied methodology to NA CISC 2019 sub-group

Table (a): CY 2019 and CY 2022 Behavioral Health service utilization by Native American Children (n = 252 children, all ages)					
Service Categories (n = 32 out of 34)	Estimated NA Children using service, CY 2019	Estimated times service was used, CY 2019	Poisson parameter: average times service was used, CY 2019	Projected NA children using service, CY 2022	Projected times service is used, CY 2022
15 min E & M	5	8	1.6	5.8	10
30 min BH therapies	42	314	7.5	48.6	393
30 min E & M	49	236	4.8	56.7	293
45 min BH therapies	55	424	7.7	63.7	528
45 min E & M	3	3	1.0	3.5	4
60 min BH therapies	5	15	3.0	5.8	19
60 min E & M	4	6	1.5	4.6	8
Applied Behavior Analysis (ABA)	1	11	11.0	1.2	14
Assessment, psych eval	103	150	1.5	119.2	193
Brief intervention & 15 min therapies	5	74	14.8	5.8	92
Case management	114	641	5.6	132.0	796
CCSS	7	94	13.4	8.1	117
CLNM Health Homes	2	22	11.0	2.3	27
Crisis triage, clinic & mobile	13	24	1.8	15.0	29
Emergency Dept	26	47	1.8	30.1	58
FFT & family therapy	96	1,809	18.8	111.1	2,250
Group therapies	22	153	7.0	25.5	192
High-Fidelity Wraparound	5	15	3.0	5.8	19
Inpatient	22	277	12.6	25.5	346
IOP, ACT	1	2	2.0	1.2	3
Medication assisted treatment	1	1	1.0	1.2	1
Non clinical congregate care	5	8	1.6	5.8	10
Over 60 min BH terapies	68	436	6.4	78.7	543
Over 60 min E & M	2	2	1.0	2.3	5
PH & Day Treatment	10	397	39.7	11.6	495
Residential & youth shelter	17	191	11.2	19.7	237
School based	39	756	19.4	45.1	943
Screening & EPSDT periodocity	192	380	2.0	222.3	479
Secondary prevention	4	51	12.8	4.6	64
Services for each	31	331	10.7	35.9	414
Treatment foster care	30	1,070	35.7	34.7	1,335
Treatment Planning	6	11	1.8	6.9	14

Description and projected # of service providers

Because service needs and availability are codependent in projecting the future-state, the workgroup identified "average caseload" information for EBP services. The average caseload assumption would also apply to workforce development efforts such as training and certification. Consequently, the workgroup is reviewing these qualifying characteristics in projecting the future-sate.

Dialectical Behavioral Therapy (DBT)

DBT is a comprehensive treatment that includes many aspects of other cognitive-behavioral approaches, such as behavior therapy, including (a) five functions of treatment, (b) biosocial theory and focusing on emotions in treatment, (c) dialectical philosophy, and (d) acceptance and mindfulness. DBT is geared to those with a serious emotional disturbance diagnosis, borderline criteria or at risk or engaged in self-harm behavior.

The average caseload size is 15 service users per worker with an average episode of care of six months. So, on an annual basis, if they practiced exclusively with this therapy, a worker could serve 30 service users per year. If it were determined they were only practicing DBT for 25% of their time they could **serve 7.5 users per year.** If there were 200 service users, it would **take 26 DBT practitioners.**

Eye Movement Desensitization (EMDR)
EMDR is a structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories.

The average caseload size is 25 service users per worker with an average episode of care of three months. Accordingly, a worker can serve 200 service users assuming this was the only therapy they were engaged in. If it were determined they were only practicing EMDR for 25% of their time they could **serve 50 users per year.** If there were 616 users needing EMDR, it would **take 12 EMDR practitioners.** There are 498 New Mexico clinicians registered and certified with the national EMDR institute.

Functional Family Therapy (FFT)
Functional Family Therapy (FFT) is an evidence-based, short term and intensive family-based treatment. FFT enrolls young adults aged 11-18 with serious behavior problems such as conduct disorder, violent acting-out, and substance abuse. FFT has a wide range of clinical applications and has been effectively integrated into a wide array of multi-ethnic, multicultural contexts.

The average caseload is 8 families per practitioner with an average episode of service being 5 months. Thus, one 5 practitioner team can serve 96 families per year. If it were determined that the team of 5 practitioners were only practicing FFT for 25% of their time they could **serve approximately 24 families per year.** If there are 309 families total who qualify for FTT in New Mexico there would be a need for **between 3 and 5 practitioner FFT teams.**

Multi-systemic therapy (MST)
Multi-Systemic Therapy (MST) is an evidence-based and intensive home-, family- and community-focused treatment for youth with serious antisocial behavior. The overarching goal of MST is to keep youth who have exhibited serious clinical problems at home, in school, and engaged in pro-social activities. Through an intensive, yet relatively short-term (3-5 month) home-based approach, MST therapists aim to uncover and assess the functional origins of adolescent behavioral and/or substance use problems and develop personalized treatment goals in collaboration with the family. MST works to alter the youth's ecology in a pragmatic manner that promotes pro-social conduct while decreasing

problem and delinquent behavior. Systems and social ecological theories, along with behavioral, cognitive-behavioral theories, form the foundation of MST.

MST is delivered to a family by a therapist who is part of a small team of 2-4 therapists plus a supervisor that are fully dedicated to providing the MST model. MST therapists are typically master's level clinicians. Because MST is delivered in the home, each MST team has a service delivery area that can expand up to 90 minutes from the office. Therapists arrange for 24/7 coverage for families. MST is listed as a well-supported intervention on the Title IV-E Prevention Services Clearinghouse, part of the FFPSA state plans, and one of the identified responses to the Kevin S lawsuit in the expansion of community-focused evidence-based services (EBP's) for kids and families.

A practitioner works with MST for 100% of their time except the supervisor who works 50% of the time MST. The average caseload **is 24 clients pers year with a team of 4 to 4 therapists**. If there are 205 service users New Mexico would need **9 MST practitioners divided between 3 to 5 MST teams.**

Trauma-Focused Cognitive Behavior Therapy (TF-CBT)
TF-CBT is a short-term treatment model that effectively improves a range of trauma-related outcomes in eight to 25 sessions, as well as addressing depression and anxiety and cognitive and behavioral problems. It involves parent participation.

The average caseload is 12 service users per worker with an average episode of care of three months. Accordingly, a worker can serve 48 service users per year if they were working exclusively with TF-CBT. Assuming they were working only 25% of their time with TF-CBT they could serve **12 users per year**. If there were 1997 service users it would take **166 service providers.**

High-Fidelity Wraparound (HFW)
HFW is intensive care coordination supporting the services and systems a youth and family already have in place or identifying new ones that may be needed. Accordingly, the wraparound approach helps increase the effectiveness of existing services. Wraparound covers all ages, and the projected utilization for an 18 to 21 age cohort is consistent with ongoing CYFD activities aimed at expanding foster care for older youth in New Mexico.

The average caseload for a service provider is 10 service users with an average episode of care of 6-12 months. Therefore, a service provider can serve between 10 and 20 service **users per year with an average of 15**. If there are 776 service users, it would take **52 Wraparound Facilitators and 7 coaches (1:8 ratio).**

Crisis Assessment Tool (CAT) and Child Adolescent Needs and Strengths (CANS)
Screenings call for CYFD to use the Crisis Assessment Tool (CAT) as an initial short screen in identifying an individual's needs within 10 days of coming into the custody of Child

Protective Services (CPS). The CAT is the first step CPS takes to identify immediate needs and referrals for community-based services or comprehensive mental health assessment.

In addition to the CAT, further screening is completed within 45 days of coming into custody using the Child Adolescent Needs (CANS) tool. The CANS tool is more comprehensive insofar as it considers the individual's experience of trauma, schooling, social and cultural identities, medical, mental health, and family needs. The CANS differentiates needs for immediate or moderate action, watching, or no action at all. Upon completion of the initial CANs (baseline) a status update follows every six months, or whenever significant events occur while in custody.

Upon completion, the CANS is used to identify specific needs, suggesting referrals to High Fidelity Wraparound, Comprehensive Community Support Services, and additional neuropsychological evaluations for example. The intent is to share the CANS information with community providers and MCOs to ensure they have a comprehensive understanding of individual needs and help identify appropriate outpatient or least-restrictive interventions.

Intensive Case Management (ICM)

High-Fidelity Wraparound, CareLink New Mexico Health homes, and Comprehensive Community Support Services are all considered intensive case management as membership in these programs is based on diagnostic and assessment criteria. New Mexico also reimburses for a service named intensive case management for eligible populations. HSD and CYFD are not considering the development of another form of this service currently.

Mobile Crisis response and stabilization: To assist in identifying usage for those services without specific identification, we have used state-level studies for mobile crisis. Even though mobile crisis is currently identified and reimbursed by Medicaid, the reimbursement is inadequate, so we have only a few units. This will be rectified by our work with the 988 initiative and grant funding. CYFD is working with Elizabeth Manley on establishing mobile crisis, or mobile response and stabilization. A breakout of the core components and approach is available in **Appendix 4** The State recognizes that children's needs are different. In New Jersey, one of the ways they were able to reform their system of care for children was using mobile response to have units accompany CPS when they were removing the child. They would establish a relationship by talking briefly to the child, family, and foster parent stating *something big just happened. Sometimes that means you (or your child) may have problems with eating, sleeping, feelings, concentrating and feel different in school. If this happens just call us, we know what to do.* This is moving upstream, predicting, and normalizing traumatic stress following a removal, regardless of the abuse or neglect suffered in the home. This is something that the State plans to achieve in time.

Step 4: Survey NM behavioral health providers and practitioners to determine both capacity and interest in pursuing the evidence-based practices.

An initial survey has been released to all behavioral health providers in NM requesting information regarding their use of both TF-CBT and FFT, and their interest in receiving support for training and certification for which they will commit to serving children in state custody for at least 25% of their caseload. (**Appendix 5**)

A survey of EMDR practitioners will be targeted at clinicians already trained and certified, as described above. CYFD has already invested in MST expansion and seeded 5 new teams last fiscal year and is in process of adding 5 more this fiscal year.

The State will also be getting quarterly or biannual data from the DVP team on claims and utilization of services tracked through Medicaid, STAR, and other mechanisms.

Future Research Steps and Timelines

The aim of the workgroup is to project service utilization for the CISC cohort, recognizing behavioral health needs, eligibility requirements, and demographics (both age and location by county). At the time of the data pull (2019) there were few codes or modifiers to delineate current EBP usage. We have identified codes and modifiers which will enable us to track the use of these EBPs. See **Table 13** for codes/modifiers. Work to publicize the modifiers is underway.

Table 13: Codes and Modifiers for EBPs

		TF-CBT	DBT	EMDR	CPP	Trauma responsive
90832	Psychotherapy, 30 min	U1	U2	U3	U4	ST
90834	Psychotherapy, 45 minutes	U1	U2	U3	U4	ST
90837	Psychotherapy, 60 minutes	U1	U2	U3	U4	ST
90853	Group psychotherapy		U2			
90846	Family psychotherapy w/o patient - 50 min	U1	U2	U3	U4	ST
90847	Family psychotherapy with patient - 50 min	U1	U2	U3	U4	ST
90847 HK	Functional Family Therapy					ST

Next steps for this deliverable include

1. Requested a proposal from New Mexico State University Center of Innovation (NMSU COI) for provider application, tracking, training, and organization of interagency committee to include representatives from CYFD, BHSD, and Medicaid. Target timeline to receive proposal, evaluate, and execute contract May 2022.

2. Develop a process within MAD to capture the requested eligibility from providers and update their system profiles so that practitioners that have been trained and certified will register their eligibility to provide these EBPs with the Medical Assistance Division (MAD). This will ensure that practitioners that have not been sufficiently trained cannot bill for these services for which we intend to offer enhanced rates. (note: MST is already a specialized service with enhanced rates.) Target timeline to completion April 2022.

3. Draft a letter of direction to the MCOs outlining how their systems must change to accommodate the modifiers and the EBP procedures. Target timeline to completion May 2022.

4. Distribute a Medicaid Provider Supplement describing the service, the training and certification process, and billing instructions. Target timeline to completion May 2022.

5. Update the Behavioral Health Policy and Billing Manual with the new EBPs. Target timeline for next manual revision July 2022.

6. On a semi-annual basis, collect data through the Data Validation team on the frequency of use which will be shared with our actuary, Mercer, who will develop rates to be made public 6 months from publication of the Supplement.