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Expanding Multi-Systemic Therapy Rapidly, Effectively and Affordably

Lessons from Other States

Executive Summary

By learning from other states, Maryland can expand Multi-Systemic Therapy, a proven community-based program that cost-effectively rehabilitates delinquent youth, with great speed, while maintaining quality. Florida sent well-prepared teams into counties and used performance-based contracting to ensure results. Several states are using federal Medicaid to offset much of the cost. California built comprehensive county-level partnerships to overcome implementation barriers. By using these tools, Maryland can more quickly address the significant unmet need for MST.

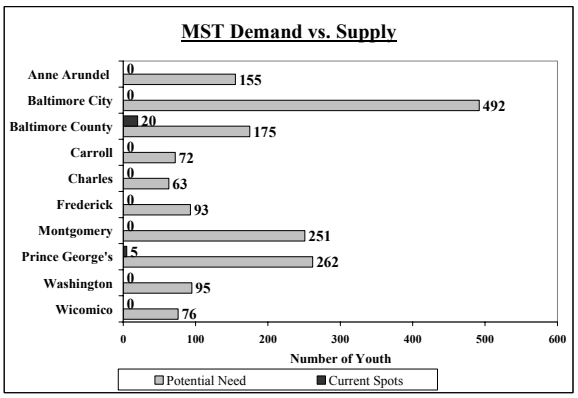
Preface

Juvenile Services Secretary Donald DeVore has indicated that he wants evidence-based services to be the hallmark of his administration. One of these services is Multi-Systemic Therapy (MST), an intensive, time-limited, in-home therapy for high-risk delinquent youth who would otherwise be placed in a residential facility.[1]

To its credit, the Department of Juvenile Services closed a residential treatment facility recently and plans to use some of the savings to create an additional 100 MST slots in Baltimore City and surrounding counties.[2]

The Children's Cabinet, which includes DJS and other child-serving agencies, has entered into a contract with the University of Maryland's Innovations Institute to develop an implementation plan to expand MST and other evidence-based services, monitor fidelity and outcomes and complete fiscal analyses.

Despite these steps, there remain many more youth who can benefit from MST than there are available slots. Chart I compares the total number of MST spots currently available to the number of potential clients, i.e., the number of youth currently in committed placements from various counties. This is the methodology used by Florida to measure unmet need.[3]



Secretary DeVore has expressed concern that services placed in Maryland demonstrate model fidelity so that they will produce the expected outcomes. As the Department continues to expand evidence-based services, several states can offer insight and lessons on cost-effective and efficient ways to overcome implementation barriers, maintain fidelity and achieve optimum capacity in tight fiscal times.

[1] See www.mstservices.com. Services are provided for four months on average, with quarterly follow-up for twelve months following completion.

[2] Julie Bykowicz, "Carroll Youth Center to Close Nov. 30," *The Baltimore Sun* (Oct., 2008). Expansion by 80 slots is proposed for Region One comprised of Baltimore City and 20 slots for Region Two comprised of Baltimore, Carroll, Harford and Howard Counties.

[3] Department of Juvenile Services, *FY 2008 Statistical Report*. The jurisdictions with the ten highest commitment rates are reflected.

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Successful Strategies

The following discussion offers guidance from other states that have successfully expanded MST.

Florida: Expanding Capacity through Legislation and Performance-Based Contracting

Florida's expansion of evidence-based practices was driven largely by state officials who were facing budget cuts and looking for programs that were both cost-effective and beneficial to its juvenile population.[4]

Aware of the successes attributed to MST, leaders invited Evidence-Based Associates into the state to conduct a needs assessment in 2004.[5] Within months, the Florida Legislature appropriated $3 million and authorized the Redirection Program, a pilot program designed to divert youth from residential facilities to evidence-based, community-based treatment.[6]

After an assessment that included an evaluation of existing services and providers and coordination with local stakeholders, Evidence-Based Associates recruited and trained 3 teams—3 trained therapists and 1 supervisor per team—and placed the teams in counties that had high numbers of committed youth.[7]

Since its inception, the Florida Legislature has expanded the admission criteria and the number of youth to be served, and the program has grown from 3 judicial circuits to 18 judicial circuits.[8] Funding has grown from $3 million to $11 million per year.[9] Most importantly, recent evaluations have calculated nearly $40 million in savings to the state, including $2 million in its first year, and reduced recidivism rates.[10]

The use of performance-based contracting has held providers accountable for results. If the services do not produce positive results, there is no cost to the state.

Along with training the service providers, EBA offered data collection and monitoring, an ongoing comprehensive quality review and assurance program to ensure model fidelity, and an independent call center that contacted families to record their experiences with the program and their therapist.

MST has other benefits besides use as an alternative to out-of-home placement. Now, Florida's Legislature is in the position to broaden the Redirection Program and serve even more youth by implementing intensive mental health services for some youth, using the program to provide transition and aftercare services in order to reduce the length of stay in residential programs, and offering specialized services for juvenile sex offenders and/or gang members.

Expanding MST with Federal Medicaid Funds

MST has been recognized as a mental health service covered by Medicaid, and some states are using federal funds to pay for a substantial part of the cost of MST.[11] Under the federal Medicaid program, states are generally able to

[4] Interview with Dan Edwards, Evidence-Based Associates (Dec. 5, 2008).
[5] Evidence-Based Associates needs assessment provides a "road map for success," including outcome targets for overall implementation of evidence-based practices, a timeline for implementation, estimated costs and estimated cost savings for shifting funding to evidence-based practices.
[6] Id.
[7] Given the intensive level of services, each therapist carries a caseload of no more than 5 youth at a time and approximately 15 youth per year. EBA reports that within three to four months of the needs assessment, teams can be recruited, trained and begin serving youth and families.
[8] Office of Program Policy Analysis and Government Accountability, *Redirection Program Achieves Lower Recidivism and a $14.4 Million Cost Savings Compared to DJJ Commitment* (June 2008).
[9] Interview with Dan Edwards, Evidence-Based Associates (Dec. 5, 2008).
[10] Florida Department of Juvenile Justice, *$16 Million Invested, $40 Million Saved* (March 2008).
[11] Jurisdictions using Medicaid funds to support MST expansion include Arizona, Connecticut, Delaware, the District of Columbia, Hawaii, Louisiana, Maine, Nebraska, New Mexico, North Carolina, Ohio, Pennsylvania and South Carolina. See www.mstservices.com

recoup 50 to 83 percent of billable costs, depending on the state's average per capita income.[12]

Many jurisdictions use techniques for billing Medicaid that result in partial reimbursements. The District of Columbia bills Medicaid for MST as a "Community Based Intervention."[13] States such as Hawaii and North Carolina have amended their State Plans and bill MST as an "Intensive Family Intervention."[14] Additional options exist under the Healthcare Common Procedure Coding System, including billing MST as a Psychiatric Rehabilitation service.

In 2002, New Mexico started a pilot program in two of its largest jurisdictions—Albuquerque and Santa Fe—using an unused code. By employing Managed Care Organizations and billing Medicaid accordingly, New Mexico has successfully expanded MST from its 2 initial treatment teams to 19 treatment teams presently. The state utilizes a daily rate that allows providers to bill for every day that a client is enrolled, not for face-to-face contact only. As a result of its MST expansion, New Mexico has seen an incremental reduction in its residential spending.[15]

Uniquely, California utilizes the Rehabilitation Option to fund MST *entirely* under Medicaid. This allows providers to bill through the county mental health plans based on a rate computed using actual minutes spent providing direct services, actual costs for providing MST, and the maximum hourly rate imposed by the California Department of Mental Health.[16]

Ultimately, billing MST using Medicaid requires collaboration with the state's department of health, mental health or public health.

Engaging Partners in Expansion Process

In order to overcome barriers to implementing evidence-based practices, including MST, the California Institute for Mental Health (CiMH) created Community Development Teams.[17] Each team is comprised of counties or agencies that are committed to implementing a new practice; the counties or agencies are represented by youth, families, other consumers, administrators, managers and supervisors, and direct service staff. CiMH brings in qualified trainers, usually the original developer of a program to train the team and help the team overcome barriers such as regulations and funding. In addition, teams have the benefit of learning about other counties' and agencies' implementation plans and receiving feedback about their own strategies. CiMH provides technical assistance, monitors fidelity and evaluates outcomes, and has found that when teams are brought together for training and implementation, long-term sustainability is higher.[18]

Conclusion

The experience of other states shows that rapid, effective expansion of Multi-Systemic Therapy is possible and produces results. Looking at these states also provides some specific strategies Maryland can use to ensure that every youth who needs MST gets it, which will save the state money and improve public safety.

[12] Cathy Surace, *Medicaid Coverage of Multi-Systemic Therapy,* NAMI Beginnings (Winter 2008). The percentages will increase under the federal stimulus legislation under consideration by Congress. Maryland's federal match rate will also increase because of rising unemployment. As such, Maryland could receive federal reimbursement for 60 percent of the cost of MST.
[13] Id.
[14] See www.mstservices.com for each state's service description and Medicaid funding standard.
[15] Interview with Ken Warner, New Mexico Children, Youth and Families Department (Jan. 29, 2009).
[16] Cathy Surace, *Medicaid Coverage of Multi-Systemic Therapy,* NAMI Beginnings (Winter 2008).
[17] Interview with Bill Carter, Deputy Director, California Institute for Mental Health (Dec. 11, 2008).
[18] The approach used by Innovations Institute in expanding evidence-based practices in Maryland is similar.