How Medicaid and Managed Care Can Support Evidence-Based Treatment in North Carolina That is Informed by Adverse Childhood Experiences

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North Carolina has increased the percentage of its clinical workforce that is proficient in evidence-based treatment and adverse childhood experiences-informed care. Medicaid and managed care have contributed through standards and reimbursement that are consistent with treatment costs. Further progress requires a concerted response from payers, policymakers, providers, and families receiving evidence-based treatment.

Adverse childhood experiences (ACEs) are not de facto indicators of child traumatic stress or a need for its treatment. Rather, ACEs represent important factors shown to predict an extensive range of negative outcomes across the lifespan [1]. Data from the North Carolina Behavioral Risk Factor Surveillance System indicate that 57.6% of North Carolina children experience at least one ACE and 22% experience 3 or more [2]. These rates are similar to national estimates. Children with emotional and behavior problems experience ACEs at higher levels; studies suggest rates from 1.65 to 4.46 times higher than children without such problems [3]. Similarly, approximately 15% of children who have experienced traumatic events develop Posttraumatic Stress Disorder [4]; among the general population, estimates of Posttraumatic Stress Disorder are lower, ranging from less than 1% to 5% [5].

North Carolina systems and providers have made substantial commitments to acquiring expertise in evidence-based treatments (EBTs) and fostering ACEs- and trauma-informed care. Mental health treatment that is informed by ACEs and traumatic stress requires an EBT-proficient clinical workforce. Short-term training approaches, such as seminars or workshops, have not improved clinicians' sustained use of EBTs [6]. Instead, training must involve detailed instruction in an EBT, consultation in providing the EBT with fidelity, assistance with overcoming barriers to providing the treatment, and sustainable revenue that is consistent with the costs incurred by providers using EBTs. A first step in providing EBTs for treatment of the sequelae of ACEs is to identify youth in need of treatment, which can be accomplished through screening across a range of child-serving systems with improved knowledge about ACEs and trauma and their effects (eg, pediatrics, social services, public health). When screening reveals significant exposure or symptoms, children may be connected with mental health providers for comprehensive, trauma-informed assessment and, when indicated, evidence-based treatment. Ongoing assessment of progress and outcomes provides data that guides clinicians in their work and allows children and their caregivers to recognize their accomplishments.

EBTs for child traumatic stress typically have been developed and validated for outpatient settings and less so for community settings where the EBT may be combined with other interventions, such as in-home supports and case management [7]. North Carolina offers a range of "enhanced services" when outpatient care has been ineffective or is inappropriate for clinical severity, such as intensive in-home services (IIHS) or "outpatient plus" [8]. Both of these services integrate psychotherapy with community and home-based interventions to assist a family in obtaining necessary care and developing more effective and practical life skills with the goal of transitioning to a lesser level of care (ie, outpatient therapy). When a treatment is transported to another setting, it is important to understand whether and how fidelity is maintained and how the more intensive service adds value and improves outcomes.

A Workforce Proficient in Evidence-Based Treatment

North Carolina has made strides toward a system of EBTs for children experiencing the sequelae of ACEs and trauma. Two examples are the North Carolina Child Treatment Program (CTP) at the Center for Child & Family

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Idzikowski sidebar

Health and the North Carolina Institute of Medicine's Task Force on Essentials for Childhood: Safe, Stable, and Nurturing Relationships and Environments to Prevent Child Maltreatment.

CTP promotes mental health workforce development by training clinicians to high levels of fidelity in EBTs for child traumatic stress while utilizing continuous quality improvement processes and tools to track participants' abilities to conduct effective treatment and monitoring progress and clinical outcomes. CTP began in 2006 as a pilot to disseminate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children in 22 northeastern counties with posttraumatic stress resulting from sexual abuse. A study of 65 licensed North Carolina mental health clinicians treating 156 clients during 2 TF-CBT learning collaboratives demonstrated significant improvements in children's posttraumatic stress, depression, and emotional and behavior problems, as well as decreases in caregivers' symptomatology. Clinicians achieved high levels of fidelity to the intervention. With higher fidelity to TF-CBT came better outcomes for children [9].

In 2014 and 2015, the North Carolina Institute of Medicine convened the Essentials for Childhood: Safe, Stable, and Nurturing Relationships and Environments to Prevent Child

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Maltreatment Task Force [10]. The task force called for a public health approach that provides care to the population of youth experiencing ACEs and traumatic stress and features: trauma-informed systems, screening, and comprehensive clinical assessment to identify treatment needs; matching those needs to appropriate treatment models; an EBT-competent clinical workforce; documented treatment outcomes; and sustainable revenue that reflects the true cost of care. A statewide collaborative to further its recommendations for EBTs, trauma-informed practice, and data use has followed.

Evidence-Based Treatments

In 2013, the North Carolina General Assembly budgeted an annually recurring appropriation for CTP to develop a partnership with state, Medicaid and managed care, and

private sector leadership to create an EBT infrastructure for child traumatic stress. The program was charged with training mental health clinicians to practice 4 EBTs with fidelity, support their sustainable implementation, and develop a statewide provider roster of clinicians meeting rigorous fidelity standards in Child Parent Psychotherapy, Parent Child Interaction Therapy, Structured Psychotherapy for Adolescents Responding to Chronic Stress, and Trauma-Focused Cognitive Behavioral Therapy.

Child-Parent Psychotherapy (CPP) is an evidence-based treatment for children from birth to age 6 who are experiencing behavior, attachment, or mental health problems secondary to trauma exposure. Randomized trials indicate improvement in child-caregiver relationships, child attachment, traumatic stress symptoms, behavior problems, and parenting [11].

Parent-Child Interaction Therapy (PCIT) is an evidence-based treatment for children aged 2 to 7 with emotional and behavioral disorders that emphasizes behavioral parent training to improve the quality of the parent-child relationship and change parent-child interactions. The efficacy of PCIT across a wide range of clinical and diagnostic presentations has been supported through multiple randomized controlled trials with evidence for sustained outcomes beyond 6 years following treatment [12].

Structured Psychotherapy for Adolescents responding to Chronic Stress (SPARCS) is an evidence-informed intervention designed to address the mental health needs of chronically-traumatized adolescents. Results from open trials suggest reductions in behavior and attention problems and posttraumatic stress symptoms, as well as interpersonal coping [13].

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a time-limited, evidence-based treatment designed to improve functioning of youth aged 3 to 18 with posttraumatic stress. Fifteen randomized trials support its efficacy for reducing child PTSD, depression, and externalizing symptoms [14].

Improving Access through Medicaid

CTP has conducted 34 Learning Collaboratives resulting in more than 800 rostered clinicians who serve 79 North Carolina counties [15]. As a result, thousands of children have received evidence-based treatment. Nonetheless, the workforce of EBT-qualified therapists falls short of the need. Similarly, North Carolina, like the rest of the country, faces a shortage of psychiatrists, resulting in poor access, especially in rural areas, to psychopharmacologic treatment [16]. All EBTs for child traumatic stress require parent and caregiver participation. Often caregivers are included in sessions or meet separately with the therapist as a component of the child's treatment. When caregivers experience posttraumatic stress or another mental health condition, their own treatment helps them to become more effective in their parenting and provide their children with the best care possible. When provided by separate clinicians working in child and adult-serving mental health contexts, the two easily can become disconnected. When integrated, child and caregiver treatment may not meet different eligibility and authorization criteria from child and adult-serving payers so that one or the other might not be reimbursed.

Medicaid represents the largest source of funding for children's mental health services in North Carolina with more than 1.8 million individuals receiving more than $2.6 billion in behavioral health services in 2016 [17]. The North Carolina Division of Medical Assistance operates under a federal Medicaid waiver [18] in which Managed Care Organizations (MCOs) receive capitated payments to manage mental health services. The waiver allows the MCOs flexibility in defining provider qualifications, managing service utilization, establishing the conditions under which EBTs will be reimbursed (eg, clinician proficiency, documented fidelity), and setting reimbursement rates to assure quality care and control rising Medicaid costs for behavioral health.

Medicaid presents an opportunity to further quality in a manner that addresses a number of existing barriers, including promoting the use of EBTs by providing a sustainable utilization management and reimbursement structure. In North Carolina, the rates for outpatient treatment act as a disincentive to using EBTs as the rates fail to reflect true costs. Treatment easily can require similar amounts of time both within sessions directly providing the EBT and outside of session activities that support treatment progress and outcomes (eg, progress and outcomes measurement, collaboration across care systems, fidelity monitoring). Several Medicaid MCOs have advanced a trauma-informed care system by emphasizing trauma-informed practitioners, use of evidence-based treatments, and differential reimbursement for clinicians meeting CTP or national rostering standards for quality and treatment fidelity. Alternative service or "in lieu of" service definitions set criteria for differential reimbursement. Some MCOs have increased reimbursement for rostered clinicians providing TF-CBT or PCIT. These rates exceed usual rates by more than 40% and have been accompanied by rates for trauma-informed assessment that are 18% higher. Although MCOs may spend more on evidence-based psychotherapy when compared to "usual" outpatient treatment, decreases in repeat episodes of care and high-intensity services more than offset these costs [19].

Conclusion

The willingness of some MCOs to reimburse some EBTs at rates that reflect providers' true costs represents an important step toward ensuring access to effective treatment for Medicaid-insured children. As North Carolina's Medicaid system changes and evolves, these developments should continue, including efforts to meet treatment needs in communities already being served, expanding access to additional communities, and supporting additional EBTs that are important for North Carolina's evolving system of

care (see Figure 1). The existing roster of clinicians meeting standards for EBT fidelity is an important aspect of workforce quality and eligibility for reimbursement, but methods for assuring the continued quality of EBT practice would ensure even greater access to highly qualified providers. With the ever-present possibility of reductions in Medicaid funding and changes in how benefits for children are managed, we cannot be certain that this progress will continue or flourish. The responsibility for sustaining and growing North Carolina's efforts to address children's ACEs and exposure to trauma through the dissemination of high-quality EBTs extends far beyond the Medicaid system and requires the dedicated efforts of policymakers, public and private funders, providers, and families receiving care. North Carolina has progressed in impressive ways, but the gains remain fragile and fall short of the great needs of children across the state. NCMJ

FIGURE 1.
Evidence-Based Treatment Resources

The "Results First Clearinghouse Database" integrates data from multiple databases that review and describe the quality of evidence for a wide range of interventions[a] to further evidence-based policy from the perspective of investment of scarce financial resources and expectable return on that investment. The California Evidence-Based Clearinghouse for Child Welfare[b] rates programs according to 5 levels of evidence from well-supported (at least 2 randomized controlled trials and outcomes that are sustained for at least one year) to concerning (negative outcomes or risk for negative outcomes). Fact sheets from the National Center for Child Traumatic Stress provide overview of more than 45 treatments, describing essential components and underlying research.[c]

[a]The Pew Charitable Trusts. Results First Clearinghouse Database. Pew Trusts website. http://www.pewtrusts.org/en/multimedia/data-visualizations/2015/results-first-clearinghouse-database.
[b]The California Evidence-Based Clearinghouse for Child Welfare. Welcome to the CEBC. CEBC website. http://www.cebc4cw.org/.
[c]The National Child Traumatic Stress Network. National Child Traumatic Stress Network empirically supported treatments and promising practices. NCTSN website. http://nctsn.org/resources/topics/treatments-that-work/promising-practices.

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