October 16, 2024

Robert Kerr, Director
South Carolina Department of Health and Human Services

Robert L. Bank, M.D., Director
South Carolina Department of Mental Health

Ms. Constance Holloway, Director
South Carolina Department of Disabilities and Special Needs

Dear Directors Kerr, Bank, and Holloway:

Able South Carolina (Able SC), established in 1994, is a leading disability-focused and disability-led organization. We seek transformational changes in systems, communities, and individuals with disabilities. Able South Carolina is a federally recognized Center for Independent Living, established under the Rehabilitation Act, run and operated by people with disabilities.

This letter serves as a demand from the disability community in South Carolina. Representing 1 of 3 South Carolinians, our voices are often neglected and are an afterthought for many of the public policies that directly impact us. The obstacles that our community faces continue to accumulate, whether due to a lack of effective communication, ableism, paternalistic policies, disregard of disability rights legislation or institutional bias. These barriers are often created for the disability community without the community's input and expertise, which is detrimental.

After receiving a significant number of complaints about disabled children in SC, particularly youth with autism and co-occurring mental health diagnoses, Able SC established a workgroup from the South Carolina Disability Public Health Coalition. Members of the workgroup are disabled young adults who recently transitioned to adult life, disabled adults, and parents of children with disabilities who have faced barriers to accessing Medicaid services within South Carolina. The goal of this workgroup was to learn about the causes of those barriers and to develop solutions so that the State can meet its obligations under disability rights laws and federal entitlements under Medicaid. Some members have had to institutionalize their children, where they were subjected to abuse and neglect, or have been unable to receive the critically needed treatment in the community. Their experiences are indicative of the system's shortcomings in supporting disabled children and youth with Serious Emotional Disturbance ("SED"), Autism Spectrum Disorders ("ASD"), and co-occurring conditions. By advocating for their rights and elevating their concerns, the workgroup is focused on ensuring disabled children and youth can remain with their families, stay in their communities, and continue attending their neighborhood schools.[1] The workgroup also consulted with an attorney from the Center for Public Representation, Steven Schwartz, a prominent attorney who has practiced disability rights and civil rights law since 1972.

Additional supporters of this letter include:

AccessAbility is a disability-led Center for Independent Living that has been serving the counties of Berkeley, Charleston, Dorchester, Orangeburg, and Williamsburg since 2001. AccessAbility promotes the full integration of people with disabilities in their communities.

Disability Rights South Carolina is the Protection and Advocacy System (P&A) for South Carolina. P&As are the only legally based advocacy organization established by Congress to protect the rights of people with disabilities. As part of that mandate, a P&A agency in every state and is working to provide legal protection and advocacy services for people with disabilities.

New Disabled South is a disability-led organization with a mission to improve the lives of disabled people and build strong disability justice and rights movements in the South. They advocate in 14 southern states, including South Carolina.

Walton Options for Independent Living is a disability-led Center for Independent Living has been serving people with disabilities in Aiken, Allendale, Bamberg, Barnwell,

Beaufort, Colleton, Edgefield, Hampton, and Jasper counties since 1994. It advocates for an inclusive community where all people with disabilities are welcomed and valued.

We bring your attention to the failures of South Carolina's Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") program for children with behavioral health and co-occurring conditions, and to identify the State's obligations to provide children with the most appropriate and least restrictive community services. Without these proper services, South Carolina is failing our children, limiting quality of life, and impeding independence during the transition to adult life. This includes the need for a comprehensive and effective EPSDT informing, outreach, screening, and treatment program, as well as an accessible pathway for waiver-eligible children to transition to home and community-based services as their eligibility expires when reaching 21.

In September 2024, the Centers for Medicare and Medicaid Services ("CMS") informed States about the policy requirements of the EPSDT mandate, identified strategies to ensure compliance with these requirements, and described best practices for achieving a fully compliant and effective EPSDT program.[2] Most components of South Carolina's EPSDT program do not meet these requirements nor conform to CMS policies. South Carolina should adopt the strategies outlined in the Guidance as soon as practicable, to improve its EPSDT program and comply with existing federal law.

As described below, thousands of Medicaid-enrolled children in South Carolina with significant mental health needs are unable to access medically necessary Intensive Home and Community-Based Services ("IHCBS") that they are entitled to receive under the EPSDT provisions of the Medicaid Act. Specifically, these children need, but are not receiving, Intensive Care Coordination, Intensive In-Home Services,[3] and Mobile Crisis Response and Stabilization Services, as defined in the 2013 Informational Bulletin jointly issued by the Center for Medicaid and CHIP Services ("CMCS") and the Substance Abuse and Mental Health Services Administration ("SAMHSA").[4]

This combination of services is widely recognized by professionals, States, and CMS as clinically effective and capable of preventing harmful and costly out-of-home placement. However, Medicaid-enrolled children with significant mental health needs and those with dual diagnoses are unable to access these services when and where they need them. Intensive Care Coordination is not covered under South Carolina's Medicaid State Plan, and, unless a child is committed to the custody of the South Carolina Department of Social Services ("DSS") or meets restrictive eligibility criteria for South Carolina Department of Mental Health ("DMH") services, is only available to a few hundred children pursuant to a 1915(b) waiver. Moreover, even this unreasonably limited capacity is not being fully

utilized. Similarly, crisis stabilization services and peer supports, like therapeutic mentoring, are not covered at all under the Medicaid program. Some covered home-based services may exist on paper, but are not readily available, due to a lack of qualified providers, insufficient provider capacity, and restrictive eligibility criteria. South Carolina's Wraparound program, which is provided by the Department of Children's Advocacy as part of its Continuum of Care, is only available to children with severe behavioral health conditions and at imminent risk of out-of-home placement, and thus serves a fraction of children with SED, ASD, and dual diagnoses who need these services. And DMH services, like Mobile Crisis, are not available to children with behavioral health and dual diagnoses. Finally, the lack of information, developmental screenings, and administrative and structural barriers also prevent children and their families from accessing necessary services, including restrictive eligibility criteria.

When these children's symptoms go untreated, their conditions worsen over time. Numerous adverse outcomes occur, including recurring mental health crises, emergency room visits, relinquishment to child welfare systems, juvenile justice involvement, and unnecessary institutionalization, particularly in its Psychiatric Residential Treatment Facilities ("PRTFs"). As a result, South Carolina is also violating children's rights under the Americans with Disabilities Act ("ADA") and Section 504 of the Rehabilitation Act ("Rehabilitation Act").

We propose a joint, collaborative effort with the State to resolve these issues and propose a process and time frame for further discussion at the conclusion of this letter. We seek to press the issue that the disability community, including Able SC and other disability advocacy organizations, must be involved in the process so we can provide critical information and reasonable, practical solutions. The disability community is protected by disability rights legislation that demands an equal opportunity to be productive citizens in the community. We believe this collaboration will result in prompt improvements in the delivery of IHCBS for Medicaid-enrolled children with significant mental health needs.

I. THE MEDICAID ACT REQUIRES SOUTH CAROLINA TO PROVIDE INFORMATION, OUTREACH, AND NECESSARY IHCBS TO ENROLLED CHILDREN WITH SIGNIFICANT MENTAL HEALTH, AUTISM, AND CO-OCCURRING CONDITIONS.

As a State participating in the Medicaid program, South Carolina *must* comply with the EPSDT provisions of the Medicaid Act for all Medicaid-enrolled children and youth under the age of 21.[5] The Medicaid Act requires the State to provide effective and accessible information and outreach to all Medicaid-eligible children and their families concerning

services covered by the program, and must include specific timelines and standards for accessing these services.[6] States must also arrange for the periodic screening of Medicaid-enrolled children that includes specific screening for developmental and behavioral conditions, to identify mental health or other medical needs early, before those conditions become serious or debilitating.[7] When this screening identifies such a need, federal law then requires a comprehensive diagnostic assessment to determine what services are necessary to correct or ameliorate the child's condition. The State must provide or arrange for those services regardless of whether they are covered in the State Medicaid Plan for adults.[8] Importantly, the Medicaid Act and its implementing regulations require that necessary services be provided in a timely way to all children with a medical need for behavioral health treatment.[9] CMS has described in detail the federal requirements for screening, diagnosing, and treating children with behavioral health needs in the community,[10] children in foster care,[11] and children with complex medical needs or other disabilities,[12] including concrete strategies that States should adopt to comply with federal law and avoid unnecessary institutionalization.[13]

II. TITLE II OF THE ADA AND SECTION 504 OF THE REHABILITATION ACT PROHIBIT THE UNJUSTIFIED SEGREGATION OF INDIVIDUALS WITH DISABILITIES.

The ADA provides "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[14] Among the forms of "discrimination" recognized by Congress and prohibited under the ADA is the needless segregation of persons with disabilities.[15] In promulgating regulations to implement the ADA, the U.S. Department of Justice ("DOJ") has required that States "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[16] The ADA's prohibition on unjustified segregation includes the unnecessary institutionalization of people with disabilities who can be served in home and community-based settings and extends to "persons at serious risk of institutionalization or segregation."[17]

In addition to requiring services and programs in the "most integrated setting," ADA regulations also prohibit public entities from utilizing "criteria or methods of administration" that have the effect of subjecting qualified individuals with disabilities to discrimination or "[t]hat substantially impair[] accomplishment of the objectives of the entity's program concerning individuals with disabilities."[18] ADA regulations also require States to make reasonable modifications in policies, practices, or procedures when those modifications are necessary to avoid discrimination based on disability, unless the

State can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.[19]

Like the ADA, the Rehabilitation Act prohibits discrimination on the basis of disability.[20] Further, the Rehabilitation Act and its implementing regulations require the provision of services in the most integrated setting, and it is a violation of the Rehabilitation Act to use methods of administration that subject individuals to discrimination.[21]

III. SOUTH CAROLINA'S FAILURE TO ARRANGE NECESSARY IHCBS FOR CHILDREN WITH SIGNIFICANT MENTAL HEALTH, AUTISM, AND CO-OCCURRING CONDITIONS VIOLATES THE MEDICAID ACT, THE ADA, AND THE REHABILITATION ACT.

A. The State is harming South Carolina's children by its failure to arrange timely access to necessary IHCBS.

Able SC routinely encounters children, youth, and families who have little understanding of the EPSDT program, no information about IHCBS services, and are experiencing unnecessary institutionalization or other out-of-home placements due to their inability to access IHCBS, including youth with significant mental health conditions, autism, and co-occurring conditions, like developmental disabilities. When children's mental health conditions go untreated, their symptoms worsen, leading to repeated, unresolved crises, unnecessary segregation, and costly out-of-home placements. Even when children are institutionalized in PTRFs or other facilities, their chronic needs are not adequately assessed, facilities do not evaluate whether those needs can be met in community-based settings, and they rarely receive referrals to IHCBS as part of the discharge planning process. Nor do responsible State agencies facilitate their access to more integrated services in the community. Instead, these children remain in overly restrictive levels of care or cycle in and out of short-term institutional placements that do not meet their chronic needs.

Examples abound in South Carolina. Able SC has been asked to assist many youth with psychiatric disabilities, SED, intellectual and developmental disabilities ("IDD"), and autism who need, but are not able to access IHCBS. For example:

"J.A." is a 13-year-old boy who is diagnosed with Autism, ADHD, and other mental health and behavioral conditions. While he excels academically, he has struggled with aggressive behavior, running away, suicidal thoughts, and damaging property. Due to the lack of intensive home-based community services in South Carolina, J.A. was recommended for

residential placement, although institutionalization is plainly not the most appropriate setting for him. Yet it appears to be the only option available. His single father is opposed to residential placement, and is firmly convinced, based upon his long-standing experience with his son, that it is not effective and even harmful for J.A.

Recently, when J.A. had an episode of aggressive behavior, his father called the managed care organization, which promptly dispatched law enforcement, causing even more anxiety and regression. Despite his clear communication of his needs, J.A. is consistently denied mental health services by DMH, claiming it does not have to serve autistic individuals or children with co-occurring conditions and sends them to the South Carolina Department of Disabilities and Special Needs, and agency that does not provide mental health services. It is important to note that J.A.'s primary needs are related to his mental health condition, not his autism diagnosis. While J.A. receives appropriate services at his school, he lacks mental health services and other behavioral supports in the community, which poses a risk to his well-being and safety. Despite numerous team meetings about his needs, there has been no substantial progress in providing him with the necessary treatment outside of school, so he can remain with his family and stay in this school.

"W. Y." is a twelve-year-old boy who lives with his parents and siblings in Fort Mill, South Carolina. Due to his behavioral health condition and co-occurring developmental disability, he often engages in challenging behaviors that disrupt and occasionally physically threaten family members. With appropriate support, he has thrived academically and is currently on a diploma track at school. However, because of a lack of appropriate, intensive home-based services that are provided with sufficient frequency and intensity, he has been institutionalized in Springbrook and several PRTFs as a result.

These are just two examples of the many children Able SC has represented, and continues to represent, who are harmed by South Carolina's failure to provide IHCBS services. These gaps in services are described in detail in both national reports.[22] The resulting systemic deficiencies are widespread and endemic, starting with the State's failure to inform, outreach, screen, assess, and refer youth to necessary IHCBS. Contrary to CMS policies and rules, South Carolina uses 1915(c) waiver authorities to supplant, rather than supplement, intensive care coordination required by EPSDT.[23] In addition, the limited capacity and restrictive eligibility criteria of the 1915(c) waiver program, the Palmetto Coordinated System of Care (PCSC), means only a fraction of children who need and would benefit from high-fidelity wraparound service coordination will receive it. Overly restrictive eligibility criteria for other wraparound services, including Psychosocial Rehabilitation Services (PRS), Family Support Services (FS), and Behavior Modification

(BMOD), prevent youth with significant mental health needs from accessing necessary treatment. These service limitations are particularly problematic for youth with dual diagnoses. Lack of access to care is further exacerbated by inadequate provider networks, the dire lack of qualified providers, and arbitrary limitations on the amount, intensity, and duration of services.

Further, services intended to divert children in crisis from more restrictive levels of care are not readily available and not delivered consistent with service specifications. For instance, families who seek Mobile Crisis Services report hours long wait times and, in the absence of a face-to-face encounter in the community, are often forced to seek help in emergency rooms that typically offer little or no mental health care. As a result, many children experience an escalation of their crisis, resulting in admissions to emergency departments, hospitals, or PRTFs. In fact, South Carolina disproportionately relies on institutionalization as its primary treatment program.[24] Many, if not most, of these restrictive, out-of-home placements could be avoided with timely access to IHCBS.

Yet another tragic consequence of the inaccessibility of IHCBS is the relinquishment of children with unmet mental health needs to the DSS, an agency that is so overburdened it takes on children and families with significant need because other state agencies are not fulfilling their responsibilities. The lack of IHCBS for all Medicaid-eligible children who need them has forced DSS to create its own, restrictive set of home-based services and an overburdened and inefficient program of care coordination. This separate network is neither adequate, appropriate, nor consistent with CMS policy.[25] Accordingly, South Carolina's failure to arrange for IHCBS shifts responsibility for these children's mental health needs to child welfare agencies who are not equipped to respond. It also deprives children of their legal right to be served in the most integrated settings appropriate for their needs.

B. South Carolina has long known about the need for and efficacy of IHCBS.

Decades of research and experience in other States has led to a consensus amongst mental health professionals that IHCBS are both clinically effective and the most appropriate services for children and youth with significant mental health conditions.[26] In States across the country, IHCBS are repeatedly recognized and approved by CMS. Professional research and federal evaluations consistently conclude that IHCBS, like Intensive Care Coordination, are most effective when provided utilizing High Fidelity Wraparound principles, standards, and practices.[27]

For this reason, federal agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA), have urged States to implement Wraparound's child and family-centered, team-based planning process in their Medicaid-funded, IHCBS systems.[28] This method has already been proven to work in South Carolina. More than a decade ago, South Carolina participated in a time-limited federal pilot program that demonstrated the ability of intensive care coordination utilizing Wraparound to prevent costly institutionalization and reduce the State's reliance on PRTFs for youth with serious emotional disturbance ("SED").[29] And more recently, South Carolina used the 1915(c) waiver authority to create a high-fidelity wraparound service for a small number of children at imminent risk of out of home placement. But even that limited capacity waiver is barely half-full. And waiver restrictions limit it to children not otherwise served by other agencies, including DSS, DMH, and DDSN.

Despite this national research on the effectiveness of IHCBS, South Carolina has long failed to provide IHCBS to all Medicaid children for whom these services are needed. Instead, it has relied upon limited-capacity pilot and waiver programs, coupled with restrictive wraparound services, for a small segment of its children with SED, ASD, and dual diagnoses who need, but cannot access IHCBS. It dramatically limited provider capacity years ago, by closing enrollment of new providers, contrary to CMS requirements.[30] As a result, these children and youth are often institutionalized in PRTFs, displaced from their families by law enforcement and put in the care of DSS, or forced into the juvenile justice system.

This failure to deliver required mental health services in South Carolina is chronic and ongoing. Periodically, State taskforces and commissions have identified deficiencies in the children's mental health system and recommended that South Carolina expand services to children and youth in their own homes and communities. Yet efforts to implement these recommendations have either stalled or are insufficient to meet the needs of children and families. As a direct consequence of these systemic failures, many children and youth have ended up in overly restrictive, segregated settings or are at serious risk of unnecessary and prolonged institutionalization as well as relinquishment to the child welfare system.

III. REQUESTED REFORMS

Federal law mandates that these deficiencies be immediately resolved. To comply with the Medicaid Act's EPSDT mandates, the ADA, and Rehabilitation Act, South Carolina must ensure that its Medicaid-enrolled children have timely, statewide access to IHCBS, including Intensive Care Coordination, Intensive In-Home Services, and Mobile Crisis Response and Stabilization Services. This legal obligation includes ensuring such services

are delivered in a timely manner and in the amount and duration that each child needs to treat their conditions and avoid unnecessary or prolonged institutionalization. Further, the State must modify administrative policies, procedures, and practices that impede or arbitrarily deny access to IHCBS and ensure that all Medicaid-eligible children and families are informed about these services, know how to access them, and can find qualified providers to deliver them.

We are hopeful that you and your respective state officials will meet with us in the next thirty days to discuss these problems and work together to identify meaningful, effective, and timely solutions. Thank you for your attention.

Sincerely,

Kimberly LaJoie Tissot
President & CEO | Able South Carolina

CC: Governor Henry McMaster
Michael Leach, SC Department of Social Services
Amanda Whittle, SC Department of Children's Advocacy
Eunice Medina, SC Department of Health and Human Services
L. Eden Hendrick, SC Department of Juvenile Justice
L. Michelle Dhunjishah, Children's Law Center Leadership

[1] Attorneys from the Center for Public Representation, a national public interest law firm with extensive experience in children's behavioral health services and the requirements of the Medicaid Act, assisted in the drafting of this letter.

[2] *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, State Health Official Letter # 24-005, dated September 26, 2024: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements ("SHO Letter 24-005"). The Medicaid Act's EPSDT provisions apply to children and youth under age 21. Our reference to children herein denotes all children and youth within this age range.

[3] Intensive In-Home Services include, among others, in-home therapy, in-home behavior supports, peer support, family support, and therapeutic mentoring, all of which are evidence-based practices endorsed by CMS and funded by Medicaid.

[4] *See, e.g.,* Center For Medicaid And Chip Services & Substance Abuse And Mental Health Services Administration, Joint CMCS And SAMHSA INFORMATIONAL BULLETIN: COVERAGE OF BEHAVIORAL HEALTH SERVICES FOR CHILDREN, YOUTH, AND YOUNG ADULTS WITH SIGNIFICANT MENTAL HEALTH CONDITIONS (May 7, 2013), at 1 (available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf).

[5] 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), (r)(5); 42 C.F.R. § 441.61(b).

[6] *See* SHO Letter 24—005 at 6-7, 9-10 (EPSDT informing policies make States ultimately responsible for providing an effective informing and outreach program, even if the program is delegated to managed care entities); U.S. DEP'T OF HEALTH & HUMAN SERVS., CENTERS FOR MEDICARE AND MEDICAID SERVS., Pub. No. 45, State Medicaid Manual § 5010.B; *see also* CENTERS FOR MEDICARE AND MEDICAID SERVS., EPSDT – A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS (June 2014) (available at: https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2262 - 64(Dec. 19, 1989).

[7] 42 U.S.C. §§ 1396a(43)(C), 1396d(r)(1)-(5). Screenings must be provided according to a set schedule established by the State (periodic screening) or whenever the child or youth receives urgent or other care (inter-periodic screening).

[8] 42 U.S.C. § 1396d(r)(5); *see also* 42 C.F.R. § 440.130; Omnibus Budget and Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2262 – 64(Dec. 19, 1989). *See also* SHO 24-005 at 7.

[9] 42 C.F.R. § 441.56(e).

[10] *See* SHO Letter 24-005 at 40-43 (noting that this requirement applies to children with behavioral health conditions, as well as those with intellectual and developmental disabilities, and cautioning against requiring children to have a particular diagnosis in order to access EPSDT behavioral health services).

[11] *See* SHO Letter 24-005 at 48-49.

[12] *See* SHO Letter 24-005 at 50-55 (noting the use of home and community-based waivers to expand the array of covered services for children with disabilities and complement EPSDT covered services; further noting the importance of seamlessly transitioning children to adult services using waiver authorities.

[13] *See* SHO Letter 24-005 at 43-47 (noting the importance of covering and ensuring timely access to intensive home-based services, including care coordination, mobile crisis and stabilization services, parent and youth peer services, therapy, and behavior intervention, in order to avoid unnecessary inpatient and residential placement unless absolutely required to treat the individual child's condition).

[14] 42 U.S.C. § 12101(b)(1). Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

[15] *See* 42 U.S.C. § 12101(a)(3). The United States Supreme Court has held that Title II of the ADA prohibits the unjustified segregation of individuals with disabilities. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999).

[16] 28 C.F.R. § 35.130(d).

[17] *See* U.S. DEP'T OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND OLMSTEAD V. L.C. (June 22, 2011) (available at: https://archive.ada.gov/olmstead/q&a_olmstead.htm). The U.S. Department of Justice is the agency charged with coordination of Section 504 of the Rehabilitation Act and Title II of the ADA.

[18] 28 C.F.R. § 35.130(b)(3).

[19] 28 C.F.R. § 35.130(b)(7).

[20] 29 U.S.C. § 794(a); 28 C.F.R. § 41.51(a).

[21] *See* 28 C.F.R. § 41.51(d); 28 C.F.R. § 41.51(b)(3); 45 C.F.R. § 84.4(b)(4).

[22] For instance, the 2020-2021 National Survey of Children's Health determined only 49.2% of children in South Carolina ages 3-17 with a mental/behavioral condition received treatment or counseling. *See* NATIONAL SURVEY OF CHILDREN'S HEALTH, (2020-2021); CHILD AND ADOLESCENT HEALTH MEASUREMENT INITIATIVE (available at: https://www.childhealthdata.org/browse/survey/results?q=9615&r=12).

[23] *See* SHO 24-005 at 54.

[24] South Carolina, with a population of approximately 5,300,00 has 467 PRTF beds, while North Carolina, with almost double that population, has only 293 PRTF beds, and even Georgia, with a population of approximately 11,000,000 people has 560 PRFT beds.

[25] *See* SHO 24-005 at 48-50.

[26] *See, e.g.*, CENTER FOR HEALTH CARE STRATEGIES, MAKING MEDICAID WORK FOR CHILDREN IN CHILD WELFARE: EXAMPLES FROM THE FIELD (June 2013) (available at: https://www.chcs.org/media/Making_Medicaid_Work.pdf).

[27] Burns, B.J. & Goldman, J.K., "Promising Practices in Wraparound for Children with Serious Emotional Disturbance and Their Families: Systems of Care: Promising Practices in Children's Mental Health," 1998 Series Vol. IV. Washington D.C.: Center for Effective Collaboration and Practice, American Institute for Research; Center of Mental Health Services, "Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program." Atlanta, GA: ORC Macro (2001); Doucette, A., Mahan, B., Dordal, L., & Bryson, N. "Taking off the Rose-Colored Glasses—Understanding Treatment Failure examining patterns of improvement and non-improvement" in C. Newman, C. Liberton, K. Kutash, & R.M. Friedman (eds.), "The 16th Annual Research Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base," Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health (2004) at 281-286.

[28] As SAMHSA has explained, "[a]lthough the term is often used loosely, over the past several decades, Wraparound has become well-defined and evaluated," with research demonstrating "positive outcomes associated with high fidelity and quality implementation of Wraparound as defined by the National Wraparound Initiative[.]" SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, INTENSIVE CARE COORDINATION FOR CHILDREN AND YOUTH WITH COMPLEX MENTAL AND SUBSTANCE USE DISORDERS (June 2019), at pg. 5 (available at: https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf).

[29] *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT TO THE PRESIDENT AND CONGRESS ON MEDICAID HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC

RESIDENTIAL TREATMENT FACILITIES DEMONSTRATION (July 2013) (available at: https://www.medicaid.gov/sites/default/files/2019-12/prtf-demo-report.pdf); Oswaldo Urdapilleta et al., *National Evaluation of the Medicaid Demonstration Waiver Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities, Final Evaluation Report* (May 30, 2012, Amended April 2, 2013) (reporting that "although Year 3 was the first waiver year for which Demonstration waiver services were purchased in South Carolina, *its grantee waiver program achieved per capita savings close to $50,000, 38 percent of comparable service costs in PRTFs.*") (emphasis added) (available at: https://www.medicaid.gov/sites/default/files/2019-12/cba-evaluation-final.pdf).

[30] *See* SHO 24-005 at 51.

Note: This effort is partially funded through funding from the Administration for Community Living's Grassroots Project. The Administration for Community (ACL) is not responsible for the content, views, or opinions expressed in this letter. The statements and information contained herein do not necessarily reflect the official policy or position of ACL.