# NH Legislative Briefing
# Reimbursement Considerations for Child Parent Psychotherapy

**February 1, 2023**

**Sponsored By:**

The Endowment for Health and the New Hampshire Children's Health Foundation

**Report Prepared By:**

Integration Sciences with Data and Child Therapist input from the New Hampshire CPP Provider Network

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## Introduction

In June 2022 the NH Legislature passed, and Governor Sununu signed, Senate Bill 444 into law with the title the "ACEs Treatment and Prevention Act." The Act was sponsored and championed by a bi-partisan group of leaders including Senators: Becky Whitley, David Watters, Erin Hennessey, Sharon Carson, Kevin Cavanaugh, Thomas Sherman, Cindy Rosenwald, Rebecca Perkins Kwoka, Suzanne Prentiss, Jay Kahn, Donna Soucy, Lou D'Allesandro, Debra Altschiller, and Representatives: Mary Wallner, Safiya Wazir, and David Luneau.

Child-Parent Psychotherapy (CPP) is specifically named in the Act as an evidence-based practice that is effective for supporting Children and their Caregiver(s) that are dealing with early trauma. The Act identifies that *"Current reimbursement rates are inadequate and do not cover costs of the professional collaboration essential to the model, costs associated with training and consultation for clinicians, or costs for program implementation, maintaining fidelity, and measuring outcomes"* and goes on to direct the Department of Health and Human Services (DHHS) to conduct a cost analysis plan.

The Endowment for Health, the NH Children's Health Foundation, and their partner organizations are highly invested in the success of this important work with NH's most vulnerable youth. Together they sponsored the creation of this Legislative Brief to inform Legislators, State Government Leaders, and other interested stakeholders of the true costs for provision of CPP services in NH. Our hope is that this Briefing will be helpful to all concerned leaders and that it will provide directional guidance to DHHS as it implements the ACEs Treatment and Prevention Act.

## Methods

This report is informed by 3 analyses [all de-identified] and by a retreat among 22 CPP providers. The 22 CPP Providers practice in 7 Community Mental Health Centers (CMHCs), 1 Federally Qualified Health Center (FQHC), 1 Intensive Home-Based Therapy & Individual Service Option (HBT & ISO) provider, and 3 private practices.

- Analysis #1 is a December 2022 overview of the 600 Children / 686 Children and Caregiver dyads that have been served by the NH CPP Provider Network.
- Analysis #2 is a time study where 22 CPP providers tracked all time spent working with or on behalf of 75 Children under CPP services for 20 working days (4 working weeks) in November of 2022.
- Analysis #3 is a cost model that identified 'ideal state' activities and timing for provision of CPP services and their associated costs.

The retreats drew upon the expertise of the 22 NH CPP Providers to understand the situations their CPP Children and their Caregiver(s) are facing, the services that are needed to support these Children and their Caregiver(s), and to review in detail the activities in the November 2022 time study.

Note: This briefing provides directional guidance to Legislators and Leaders within DHHS and is not intended to be a formal rate setting process as defined by the Center for Medicare and Medicaid Services.

# Findings

## Introduction

An estimated 37,441 or ~40% of NH's 91,319 children age 0-6 have faced at least 1 Adverse Childhood Experience (ACE).[1] ACEs, according to the Centers for Disease Control and Prevention, are potentially traumatic events including:

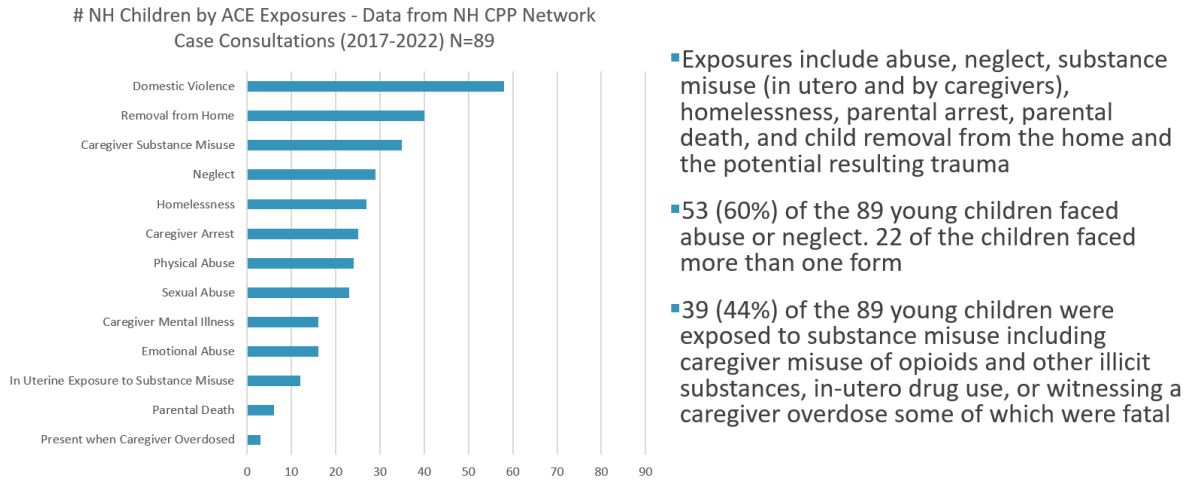
- Experiencing violence, abuse, or neglect
- Witnessing violence in the home or community
- Having a family member attempt or die by suicide

The CDC also points out that ACEs include aspects of a child's environment that "can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use problems, mental health problems, and instability due to parental separation or household members being in jail or prison."[2]

## Scope and Nature of ACEs in NH

Since 2017, NH Child-Parent Psychotherapy (CPP) clinicians participating in the CPP Learning Collaborative training process have been presenting CPP cases to track fidelity to the model. CPP includes assessing child and caregiver exposure to traumatic events and the impacts of those exposures. An analysis of the 89 case presentation write-ups demonstrates the type and scope of trauma that many of our state's Children and their Caregivers have been facing.

*Figure 1: NH Children Exposures to ACEs*



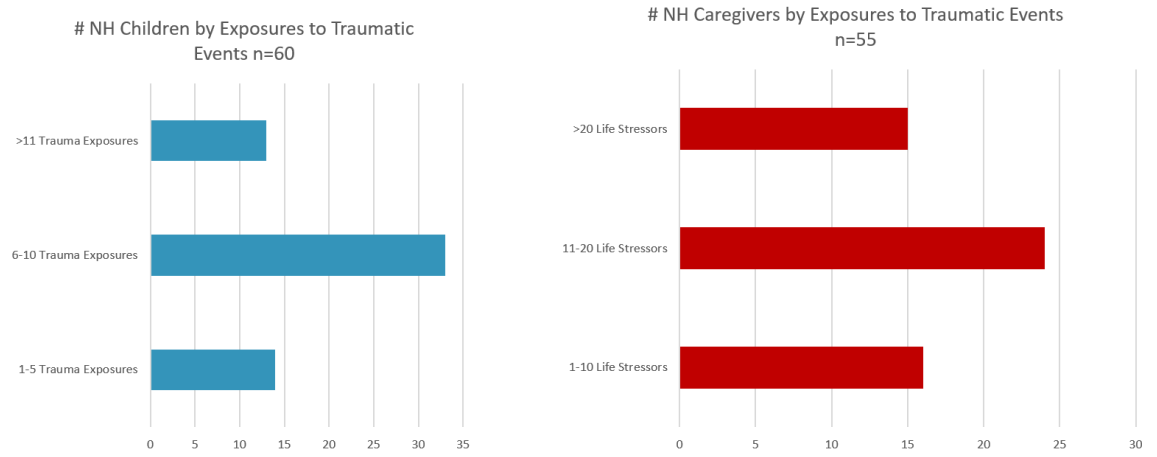

*Source: ACE exposure data from NH CPP Network Case Consultations (2017-2022) N=89.*

[1] Sacks, Vanessa. Murphey, David. 'The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity.' February 12, 2018, Child Trends. https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity

[2] Center for Disease Control and Prevention, Violence Prevention, Adverse Childhood Experiences informational webpage, https://www.cdc.gov/violenceprevention/aces/fastfact.html

The Children and their Caregivers were also assessed for exposure to traumatic events using assessment tools from the US Department of Veteran's Affairs, National Center for Post-Traumatic Stress Disorder (PTSD). Children were screened using the "Traumatic Events Screening Inventory for Children (TESI) "and adults were screened using the "Life Stressor Checklist--Revised (LSC-R)."[3]

*Figure 2: NH Children and Caregivers exposure to Traumatic Events*




*Source: ACE exposure data from NH CPP Network Case Consultations (2017-2022) including: Results of "Traumatic Events Screening Inventory for Children (TESI);" and, Results of Caregiver exposure to trauma measured using the "Life Stressor Checklist--Revised (LSC-R)."*

The data is heartbreaking:

- Childhood exposures include abuse, neglect, substance misuse (in utero and by caregivers), homelessness, parental arrest, parental death, and child removal from the home and the potential resulting trauma.
- 53 (60%) of the 89 young children faced abuse or neglect. 22 of the children faced more than one form of abuse (physical abuse, sexual abuse, emotional abuse, neglect).
- 39 (44%) of the 89 young children were exposed to substance misuse including caregiver misuse of opioids and other illicit substances, in-utero drug use, or witnessing a caregiver overdose some of which were fatal.
- Children screened using the "Traumatic Events Screening Inventory for Children (TESI)" had an average of 8 exposures to traumatic events with a range of 1 to 17 total exposures.
- Caregivers using the "Life Stressor Checklist--Revised (LSC-R)" had an average of 15 exposures to traumatic events with a range of 3 to 28 exposures.

Since 2017, the NH CPP Provider Network has recorded about 600 children who have participated in CPP. Clinicians registered 686 dyads which represent those 600 children plus a caregiver, and in several instances, multiple caregivers who participated in therapy with the child.

- The average age of children participating in CPP is 4.75 years old

[3] US Department of Veteran's Affairs, National Center for Post-Traumatic Stress Disorder (PTSD). https://ptsd.va.gov/

- There are slightly more males (52%) than females (48%)
- The most common caregiver participating in dyadic therapy is the biological mother (44%)
- In 10% of cases, both the biological mother and biological father are participating.
- Other common participants include the biological father (19%), foster parents, (16%), grandparents (10%), other family members (grandparent, great grandparent, aunt, stepparent) (9%), adoptive parents (5%)
- Sixty-five percent of families have current or previous involvement with DCYF (37% have current DCYF involvement, 28% have previous DCYF involvement)

## NH Legislative Action and the ACEs Treatment and Prevention Act of 2022

The New Hampshire Legislature has prioritized the support of Children who have experienced Adverse Childhood Experiences. Through the ACEs Treatment and Prevention Act of 2022, Child-Parent Psychotherapy (CPP) has been identified as the foremost evidence-based practice for supporting NH Children and their Caregiver(s) who face the most formidable challenges. CPP has been identified on the major evidence-based practice clearinghouses including: Title IV-E Prevention Services Clearinghouse, California Evidence-Based Clearinghouse, and the National Child Traumatic Stress Network. The NH Legislature recognizes that there is a pressing need to support traumatized Children and their Caregiver(s) and that this presents the most promising opportunity to interrupt intergenerational trauma, violence, crime, and substance misuse over the long term.

The Legislature's focus on Child and Caregiver aligns well with the rollout of the federal 'Family First Prevention Services Act of 2018 (FFPSA).' The FFPSA's focus is toward keeping children safely with their families when possible to minimize exposure to trauma. The law is intended to provide families with improved access to mental health, substance misuse treatment, and parenting services.[4] The FFPSA is accompanied by the "Title IV-E Prevention Services Clearinghouse" which contains a list of evaluated and tested prevention services and programs that may be funded by states using title IV-E funds. CPP is listed on the Clearinghouse.[5]

To bring the NH Legislature's vision to life and to fulfill the promise of the ACEs Treatment and Prevention Act, NH will need to attract, retain, and train a highly-skilled workforce to support Children who have experienced ACEs. Given the acute shortage of behavioral health professionals in NH [and nationally], workforce building is the priority. The Legislature identified that provision of CPP services is undercompensated and directs the Department of Health and Human Services (DHHS) to conduct a cost analysis. This report was prepared to help inform the Legislature and guide DHHS as it undertakes this work.

[4] US Department of Health and Human Services, Child Welfare Information Gateway, Family First Prevention Services Act, https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/family-first/

[5] Title IV-E Prevention Services Clearinghouse, https://preventionservices.acf.hhs.gov/program?combine_1=Child-Parent+Psychotherapy

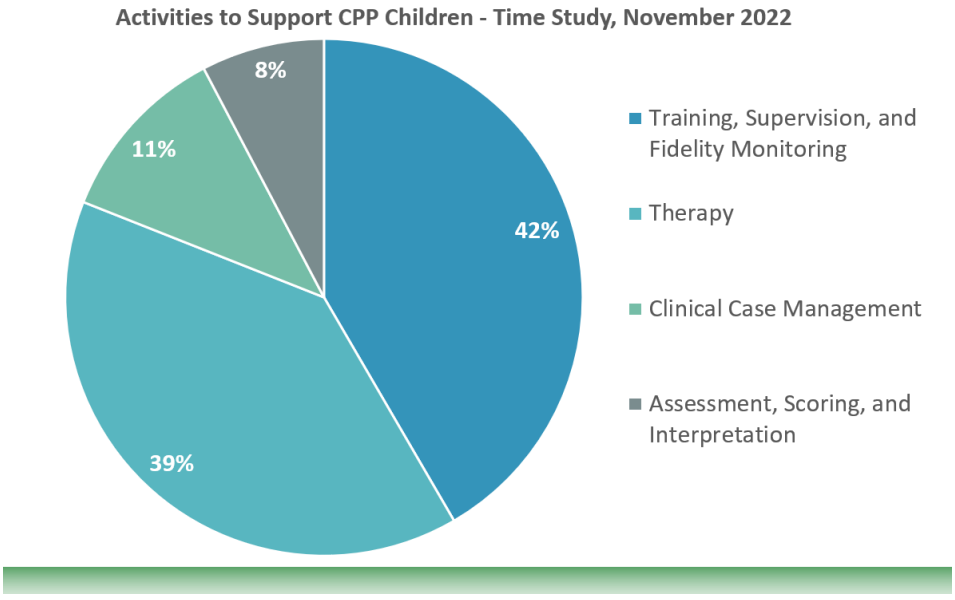
## Time Study with the NH CPP Provider Network

Prior to CPP implementation in NH, the capacity for mental health intervention for young children was negligible. With early philanthropy funding from the NH Children's Health Foundation and with grant funding, the *NH CPP Provider Network* was created to recruit, train, and sustain an interdependent network of CPP-trained mental health clinicians. It is a unique model where child therapists continue to perform their work with Children and Caregivers within their organizations (e.g., Community Mental Health Centers, Partial Hospitalization Programs, HBT and ISO Programs, Private Practice) while collaborating for the rigorous training, supervision, and fidelity monitoring requirements of the CPP evidence-based practice.

The Network's purpose has been to increase access to CPP for NH's youngest, most traumatized children and it is succeeding in its mission. For nearly a decade the Network has been building workforce capacity to address the thousands of young children involved with the child welfare and foster care systems due to impacts associated with the opioid crisis and supporting children and caregivers with exposures to ACEs and associated trauma. 147 providers have been rostered in CPP through the NH CPP Provider Network raising the estimated capacity of the state to over 1,000 Child and Caregivers annually.

A November 2022 time study of 22 NH CPP Providers shows the range of activities required to deliver the CPP model to fidelity. Based on the time study, activities fall broadly into 4 categories as shown in the figure below.

*Figure 3: CPP Time Study Activity Breakout, Nov 2022*




**Training, Supervision, and Fidelity Monitoring:** During the time study CPP Providers spent 42% of total time engaged in Supervision activities. Supervision encompasses the primary activities identified in the ACEs Treatment and Prevention Act including professional collaboration, training and consultation for clinicians, fidelity, and measuring outcomes. Due to the complexity of the situations the CPP Children and their Caregiver(s) are facing, the CPP evidence-based practice is extremely rigorous. The initial 18-

month training and supervision program requires time investment above and beyond the typical requirements for child therapist training, supervision, and licensure.

Supervision encompasses fidelity monitoring where new CPP providers meet frequently with supervisors, consult with other providers on cases, and present formally for fidelity review. Supervision is required to assure the safety, wellbeing, and continuity of care for young traumatized children. This is a strength of the CPP rostering process as it encourages safety, close adherence to the evidence-based practice, support from more experienced providers, and formal measurement of fidelity.

126 Hours of Supervision activities (~7 Hours per Month) are required in the initial 18 months of learning and practicing the CPP evidence-based practice. Once a Provider has completed the initial 18-month requirements and has been 'rostered' to practice CPP, the Supervision requirements step down to 2-3 hours per month.

**Therapy:** During the time study CPP Providers spent ~39% of total time with CPP individuals conducting therapy. Under the evidence-based practice, this includes therapy with the child's Caregiver(s) and therapy with dyads that include one or more Caregivers and the Child. As shown in the findings above, the dyads most frequently include the Child and Biological mother as the primary caregiver. However, there may be multiple caregivers involved simultaneously or the primary caregiver may be a Foster Parent, a Grandparent, a Biological Father, or a legal guardian that is another family member or caregiver.

CPP is designed to be an intensive dyadic intervention meaning multiple sessions are conducted weekly in most cases. In a typical week, the CPP Provider will conduct a 1 Hour Therapy session with the Primary Caregiver and a 1 Hour Therapy session with the Child / Primary Caregiver dyad at a minimum and will occasionally conduct additional sessions with other caregivers. The frequency is important for young children given their memory processes and need for co-regulation.

NH Medicaid, the NH Medicaid Managed Care Organizations (MCOs), and most private health insurers currently reimburse CPP Providers for Therapy activities. Most of these NH Payers also recognize the value of Caregiver involvement in therapy and provide reimbursement for the Caregiver of a Child regardless of the Caregiver's insurance status or Health Insurer. These are strengths in the current reimbursement structure.

**Clinical Case Management:** During the time study CPP Providers spent 11% of total time on behalf of CPP individuals providing Clinical Case Management support. In CPP practice this is called "concrete assistance." Due to the childhood trauma complexity of the individual cases, the therapist needs to be closely involved in clinical case management. This may be accomplished efficiently through multi-provider coordination as supported through NH System of Care or may be managed directly by the Provider. In the time study, CPP providers dedicated time to coordinating with the following:

- **Caregivers:** Significant effort is required outside of therapy time to coordinate with caregivers, to keep them engaged in the program, to answer complex questions, and to maintain communication channels. It is paramount to develop a trusting relationship with the families and then to work diligently to monitor and assure the ongoing safety of the child and to interrupt any placement disruptions.

- **Division for Children, Youth and Families (DCYF):** Given that 65% of CPP families are currently or previously involved with DCYF, frequent coordination between the CPP provider and the DCYF case worker is needed. This is particularly important in supporting decisions surrounding a Child's placements. This may include coordination with Child Advocacy Centers, Court appointed special advocates (CASAs), and guardian's ad litem (GALs).
- **Schools:** With an average age of 4.75 years, many CPP Children are in early learning and school environments and require frequent coordination among the CPP Provider and educators. Most children involved in CPP present with emotional and behavioral difficulties, and as a result, are disproportionately suspended, expelled, and involved in disciplinary action. Coordination can help interrupt disciplinary cycles. School coordination includes formal periodic input for Individual Education Plans (IEPs) and 504 plans as well as less formal and more frequent coordination and communication with the school teaching, counseling, and special education teams. Schools also manage Child Find Under Part B of the Individuals with Disabilities Education Act opening up another point of coordination around child identification for CPP and special education.
- **Family Centered Early Supports and Services (FCESS):** Coordination is required with the FCESS team for those age 0-3 that are at substantial risk for a developmental delay.
- **Concrete Supports:** CPP families face many challenges meeting basic human needs (e.g., Food, Shelter, Transportation, Childcare, Utilities) and providers dedicate time to helping them navigate and access supports in their communities. Some basic needs case management may be supported by an agency case manager but often the CPP provider needs to stay engaged due to the complexity of the situations.
- **Pediatrician / Primary Care Provider:** Coordination is required for periodic medication management and for tracking and supporting child development (e.g., Age-appropriate weight, height, mobility, and speech) and basic healthcare needs.
- **Courts and Law Enforcement:** Some CPP families are involved with law enforcement and the court system and require coordination between the CPP provider and the Court. This may include coordination with Child Advocacy Centers, CASAs, and GALs.
- **Caregiver's Behavioral Health Providers:** Caregiver mental illness and substance misuse are common and directly impact the Caregiver's capacity for supporting their Child. Coordination is required with behavioral health providers.
- **Transition of Care:** CPP families are often transient and require support to transition from one provider to another. CPP providers also consult regularly with other Providers to determine if Children should be enrolled in CPP services.

**Assessment, Scoring, and Interpretation:** During the time study CPP Providers spent 8% of total time on case conceptualization. Case Conceptualization typically requires 15 minutes of work for each Therapy session. Assessment is a part of every CPP session. A full assessment battery is a critical component of CPP and that the scoring and interpretation are a large task akin to [but not the same as] conducting a psychological evaluation. Required activities include reviewing the assessment(s) completed during the therapy session, scoring the assessment, interpreting the results, and entering the information into the EMR to be included in the Progress Note and Treatment Plan.

## Recommendations

As the State of NH moves forward with the implementation of the ACEs Treatment and Prevention Act of 2022, it will be well served by setting up payment conditions that encourage Providers to: Enter the field of Child Therapy; Pursue the extra training and supervision required to be rostered to deliver the Child-Parent Psychotherapy (CPP) evidence-based practice; and, Serve NH Children and their Caregiver(s) with Adverse Childhood Experiences (ACEs) over the long term. The State may build upon the assets and strengths that are already in place including:

- The NH CPP Provider Network for efficient and scalable Training, Supervision, and Fidelity Monitoring
- The NH System of Care for collaborative case management for our children and families facing complex care management challenges
- NH Medicaid and the Private Health Insurers for their recognition of the need and commitment to provide coverage of not only the Child but also the Caregiver

The state faces the challenge of building sufficient capacity among Child Therapists to serve Children and Caregivers in their recovery from ACEs across NH. The following directional recommendations may help state leaders to accomplish these goals.

There is an underlying assumption in this briefing that the state will raise the funds needed for upfront investments in CPP Child Therapist capacity building and ongoing support for the professionals who do this very challenging work each day. This work will be expensive but there are clear revenue pools to draw upon right now above and beyond NH Medicaid and Private Health Insurance Providers including:

- Families First Prevention Funds – Title IV-E funding
- Opioid Settlement and State Opioid Response (SOR) funding: (Note that nearly ½ of the Children in the CPP consultation group had exposure to substance misuse. DCYF also tracks exposure of Children to substance misuse. A solid case may be made to access current and pending/future opioid focused funding pools.)
- NH's Alcohol Fund
- Federal stimulus funding
- Federal mental health block grants

Note that this briefing was not intended to quantify "return on investment." There are hypotheses that a year of CPP interventions may result in significant long-term savings across the education, healthcare, behavioral health, and judicial systems but that is beyond the scope of this briefing.

**Recommendation 1 – Set Minimum Capacity Target:** Quantify the level of need, the current capacity to meet that need, and the target capacity.

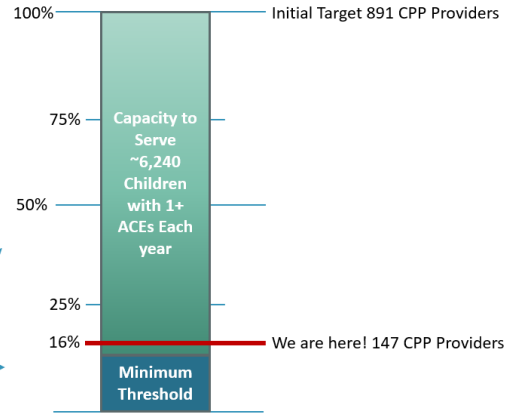
An estimated 37,441 NH children age 0-6 have experienced at least 1 ACE. While it is unconscionable to ask state leaders to determine how many exposures to ACEs justify a CPP intervention, it will be helpful to establish an initial target number of Children and their Caregiver(s) who need CPP support each year along with a target for CPP Provider capacity. This will be a helpful guide in determining capacity strengths and gaps. The targets themselves may evolve over time with data and further study.

*Figure 4: Estimate of Number of Children in Need and Minimum Number of CPP Providers to Meet That Level of Need*

Estimated NH Children Age 0-6 in Need of CPP

| Estimate of Need | # |
|---|---|
| Est. NH Population Age 0-6 | 91,319 |
| Est. NH Children Age 0-6 with 0 ACEs – 59% | 53,878 |
| Est. NH Children Age 0-6 with 1 ACE – 22% | 20,090 |
| Est. NH Children Age 0-6 with 2 ACEs – 12% | 10,958 |
| Est. NH Children Age 0-6 with 3-8 ACEs – 7% | 6,392 |
| | |
| Annualized Aspirational Target – Based on serving NH Children Age 0-6 with 1+ ACEs | **6,240** |
| Annualized Minimum Target - Based on NH DCYF Child Victims Age 0-6 adjusted for non-DCYF involved children | **915** |

NH CPP Providers Capacity - Annually




Detailed notes on the needs and capacity:

- Estimation of need is based on a percentage of Children age 0-6 with 1 of more ACE[6] applied to the US 2020 census count for NH children age 0-6.[7]
- The minimum threshold target of 915 Children age 0-6 is based on 595 NH DCYF Child Victims Age 0-6 adjusted upward by 320 for non-DCYF involved children using DCYF involvement data from the NH CPP Provider Network.[8][9]
- The needs in the model are annualized. The minimum target is an annual number. The Aspirational target assumes a steady state of serving 1/6 of the population with 1-year intervention over span of 6 years.
- Minimum CPP Capacity was derived by comparing annual needs to required CPP providers assuming a 7:1 maximum ratio of Child to Provider.

**Recommendation 2 – Determine Level of Effort per Child and Caregiver:** Recognize the full package of services needed to support a Child and Caregiver in CPP practice.

When delivered in the ideal state, CPP practice requires ~16 hours per month per child of a Child Therapist's time plus 2-7 hours per month for Supervision activities. See the figure below.

[6] NH ACEs estimates: Sacks, Vanessa. Murphey, David. 'The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity.' February 12, 2018, Child Trends. https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity

[7] Source: United States Census Bureau, NH Statistics, 2020 decennial census, https://data.census.gov/profile/New_Hampshire?g=0400000US33

[8] Source: "Child Maltreatment 2020," U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

[9] Analysis of DCYF involvement for 600 Children / 686 Children and Caregiver dyads that have been served by the NH CPP Provider Network (Dec 2022)

*Figure 5: Estimated Level of Effort to Support Children and Caregivers using CPP*

Activities to Support Children with ACEs

- CPP Therapy
- Clinical Case Management
- Assessment, Scoring, and Interpretation
- Training, Supervision, and Fidelity Monitoring

Estimated Level of Effort – Ideal State

| Activity | Hrs. p/ Month |
|---|---|
| **Therapy** Minimum of 1 Caregiver and 1 Child/Caregiver dyad session per week | **8** Hrs. p/ child p/month |
| **Clinical Case Management** Coordination with DCYF, Schools, Pediatrician / Medication Prescriber, Early Supports and Services, Family Resource Center, System of Care, Substance Misuse Providers, Courts and Law Enforcement, and with Caregivers. | **6** Hrs. p/ child p/month |
| **Assessment, Scoring, and Interpretation** Minimum of 15 minutes for every hour of Therapy. Includes: Assessment Scoring and Interpretation, Charting including Progress Note and Treatment Plan, session Preparation | **2** Hrs. p/ child p/month |
| **Training, Supervision, and Fidelity Monitoring** Training, Consultation, Preparation, Fidelity monitoring, Measurement | **7** Hrs. p/ Provider p/mo. for 18 mos. **2** Hrs. p/ Provider p/ mo. after 18 mos. |

The estimated monthly level of effort above is derived by considering all categories of support activity identified through the CPP time study followed by an estimation of ideal level of effort for all activities. CPP is typically an episodic intervention with a formal program that lasts for 12 months followed by planned discharge from services though there are accelerated variations (most typical for HBT ISO providers).

**Recommendation 3 – Up Front Investment in Staff:** Support Child Therapists to work through the rigorous 18-month training and supervision requirements.

The initial 18-Months of training and supervision requires a minimum of 126 hours to complete. This averages out to ~7 hours per month.

*Figure 6: Estimated Level of Effort to complete Initial 18-Month Training and Supervision for CPP Rostering*

Estimated Level of Effort – Dictated by CPP Rostering Requirements

| Supervision Requirement | Description | Total Hrs. |
|---|---|---|
| Attend Initial CPP Didactic Training | 3-day Training | 24 |
| Read the CPP manual | 4 Hours minimum, many return to manual frequently for guidance. | 4 |
| Present 4 Cases for Consultation | 4 Cases, 1 hour per case | 4 |
| Group Consultation on Supervision / CPP Reflective Supervision | 25 Hour Minimum requirement | 25 |
| CPP Consultation Calls | 23 Hour Minimum requirement | 23 |
| Case Presentation – Preparation | | 2 |
| Intensive CPP Competency Building Workshop(s) | 4 Full Days of Training | 32 |
| Fidelity Monitoring / Measurement | 2 Cases Minimum, 3 Times (every 6 months min), 2 Hours per Case | 12 |
| **Total (over 18 Months)** | | **126 Avg. 7 per Month** |

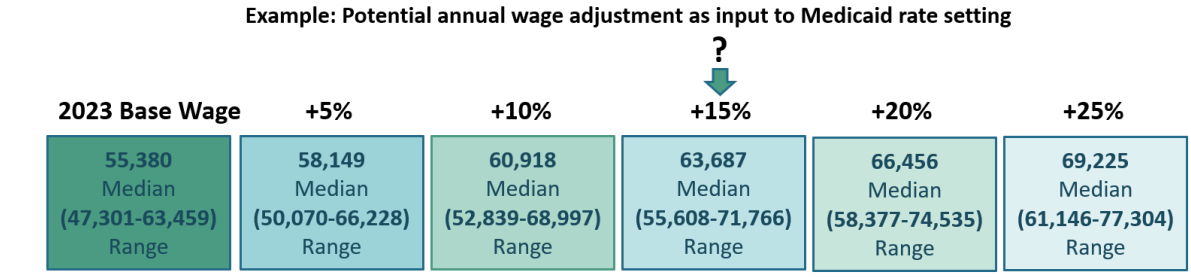
The estimate above is based on the requirements for CPP rostering.[10] After 18 months, Supervision requirements step down to 2-3 Hours per month.

There are two types of opportunities for NH to reduce the barriers to entry for CPP rostering. The first opportunity is to compensate Child Therapists (via their organizations) for time spent on Training, Supervision, and Fidelity Monitoring. The second opportunity is to provide financial support for those who provide the Training, Supervision, and Fidelity Monitoring. As mentioned in the Finding section above, the NH CPP Provider Network is well established in the state, it operates an efficient and scaled capability for supporting Child Therapists through the entire CPP rostering process, and it can play an important role in future growth if sustained financially.

**Recommendation 4 – Differential Reimbursement for CPP EBP:** Enact a one-time reimbursement adjustment to attract and retain sufficient workforce.

Given the capacity targets above, the Department may consider a significant reimbursement adjustment for Child Therapists practicing the CPP evidence-based practice (or more generally for EBPs). One way this may be accomplished is by adjusting the annual wage assumptions that underlie Medicaid Rate Setting. The following example, data, and assumptions may guide Medicaid's efforts to set reimbursement conditions that can attract talented Child Therapists to practice CPP in NH.

*Figure 7: One-time wage adjustment to attract and retain workforce*




**Example assumptions:**

1. 2022 Base annual wage set at 52,000 based on two inputs:
   a) 51,938 = Average annual salary of 11 NH CPP Providers that participated in November 2022 time study.
   b) 51,952 = Median Annual Wage from Salary.com Child Therapists (Filtered for Manchester, NH) (2022) (source: Salary.com HR Wage Data for Child Therapist (filtered for Manchester NH) https://www.salary.com/tools/salary-calculator/child-therapist/manchester-nh)
2. Range set at 8,079 based on delta from 75th percentile to 25th percentile from Salary.com Child Therapists (Filtered for Manchester, NH) (2022) (source: Salary.com HR Wage Data https://www.salary.com/tools/salary-calculator/child-therapist/manchester-nh)
3. 2023 wage adjusted for annual inflation using 6.5% Consumer Price Index adjustment from US Bureau of Labor Statistics, 12 Month Consumer Price Index - All Items, December 2022. https://www.bls.gov/cpi/

In tandem with rate correction is the inclusion of all CPP required activities in Recommendation 2 in reimbursement. This may be accomplished in a variety of payment models including Fee for Service, Capitation, and Bundled Rates.

[10] Child Parent Psychotherapy, Learning Collaborative, Training Requirements for CPP Rostering, see website: https://childparentpsychotherapy.com/providers/training/lc/

## Recommendation Conclusion

The delivery of the Child-Parent Psychotherapy evidence-based practice in NH requires significant up-front investment in Training, Supervision, and Fidelity Monitoring. This barrier to entry may be offset by reimbursing Child Therapist time and by funding those that support CPP rostering in NH.

The delivery of CPP to fidelity includes ongoing investment in time for Therapy, Clinical Case Management, and Assessment. All activities should be covered for reimbursement.

NH has a great start with building CPP Provider capacity to meet the needs in NH with ACEs. Still there is much more to do to attract, train, and retain qualified Child Therapists. Differential reimbursement for CPP EBP with an underlying wage adjustment can support these goals.

## Acknowledgements

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