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Partnering with Medicaid to Advance and Sustain the Goals of the Child Welfare System

Jennifer Lowther, LCSW-C
Deborah S. Harburger, MSW
Suzanne Fields, MSW
Michelle Zabel, MSS
The Institute for Innovation & Implementation, University of Maryland School of Social Work

Sheila A. Pires, MPA
Human Service Collaborative

Kamala D. Allen, MHS
Center for Health Care Strategies

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Abstract

The purpose of this paper is to serve as a practical guide for child welfare directors who are looking to expand or sustain services for the children and families that they serve. This paper focuses on ways to partner with Medicaid to leverage opportunities to provide high quality services for children in child welfare who have behavioral health needs. It also includes information that will provide a foundational understanding of the behavioral health needs of children involved with the child welfare system, with an emphasis on describing child behavior through the lens of child development, adaptive functioning, and trauma; the services that can effectively address those behavioral and trauma related responses that can disrupt a child's skills and abilities; and, examples from states and counties who are providing these services and supports.

Introduction

The child welfare field has been referred to as a calling by dedicated professionals. Child welfare agencies serve one of the most vulnerable populations of children. These children are either in the midst of an allegation of maltreatment towards them or have been removed from their caregiver's custody due to a high risk for and/or experience of harm or neglect. Once these vulnerable children come to the attention of the child welfare agency, the daunting responsibility of the child welfare worker begins, including rapidly ensuring safety; assessing needs, strengths and functioning; and, identifying long term permanency plans. This is a huge charge that requires the child welfare agency to address many complex issues that include the behavioral, oral, physical, developmental and educational health of children and the caregivers (Children's Bureau, 2013a).

It is a complicated process to uncover the extent to which adverse circumstances have impacted the development of children involved with the child welfare system. Chronic and complex traumas are pervasive and evident in the majority of children involved with the child welfare system, despite the resiliency and inner fortitude that many of them may exhibit (Office of Planning, Research & Evaluation, 2013). Effectively and efficiently assessing how to meet each child's unique behavioral and developmental needs entails strong partnerships with school systems, law enforcement, juvenile justice, behavioral health and medical providers – professional partners that know and can help child welfare-involved children (Taylor & Siegfried, 2005). Sister child- and family-serving agencies, such as state Medicaid authorities and their provider networks that exist in each state and county are key resources, equipped with psychiatrists, social workers, psychologists, and other trained professionals to meet apparent or hidden behavioral health challenges. It is important to connect early with child-trained Medicaid providers for thorough developmental and behavioral health screenings in order to identify services and supports that can best serve the individual child and family (Sheldon, Tavenner, & Hyde, 2013).

What Are the Behavioral Health Needs of Children Involved with the Child Welfare System?

Children entering the child welfare system come from a myriad of unsafe and unstable home circumstances. Despite this, the act of removing children from their homes (even homes that were scary and unpredictable) is a traumatic one. Now in foster care, children may be experiencing the loss of family (including separation from siblings) and community and uncertainty of what to expect. They may be undergoing potentially stressful and inconsistent visits with their family as the child welfare agency works to preserve and reunify them. How does a child cope with these life stresses? They do the best that they can.

Many children involved with child welfare experience anxiety, aggressive and negative behaviors, and nightmares. These can be signs and symptoms of attachment disorders and post-traumatic stress. These traumatic experiences can cause a child to have emotional dysregulation, loss of direction, and an inability to detect and react to dangerous cues (Dvir, Ford, Hill & Frazier, 2014). These maladaptive behaviors extend very quickly to their daily lives. However, children impacted by maltreatment often find the expectations of daily living hard to meet. Many children involved with the child welfare system have experienced living in households where their caregivers could not give them what they needed at the most basic level and, as a result, they may not trust adults and try to avoid adult relationships: "When adult responses to children are unreliable, inappropriate, or simply absent, developing brain circuits can be disrupted, affecting how children learn, solve problems, and relate to others" (Center on the Developing Child, 2016).

Mental health disorders often have biological and genetic origins. Even without experiencing maltreatment, some of the children in the child welfare system likely would be experiencing some form of mental health disorder, such as anxiety, depression, or phobias. These conditions are compounded when experienced in conjunction with traumatic experiences, both before and during child welfare placements (Dvir, Ford, Hill & Frazier, 2014; Taylor & Siegfried, 2005).

> "The negative consequences of deprivation and neglect can be reversed or reduced through appropriate and timely interventions, but merely removing a young child from an insufficiently responsive environment does not guarantee positive outcomes. Children who experience severe deprivation typically need therapeutic intervention and highly supportive care to mitigate the adverse effects and facilitate recovery." *The Harvard Center for the Developing Child, 2016*

Children are resilient and develop coping skills to get by day to day. These adaptive behaviors can look like negative behaviors, such as theft and lies to meet basic needs and protect their loved ones or using alcohol and drugs to numb pain from grief, loss, and stresses of having lived in extreme poverty. Children involved with the child welfare system may have impaired adaptive functioning, which can mean that they do not handle common demands on them and perform as independently as children who have not lived through traumatic events (Dvir, Ford, Hill & Frazier, 2014). Despite the child welfare system's best intensions, the very act of coming into foster care can be very traumatic; the uncertainty of foster placements and re-placements can also be unsettling and destabilizing. The burden and disruption of their family life and unclear future are overwhelming.

Child welfare administrators should anticipate that the children and youth in their care may experience difficult interactions with peers, adults and family members; minimal impulse control; withdrawal from social interactions; self-care neglect; deterioration of physical health; and, inability to maintain appropriate school behavior or academic achievement. All children will not experience all of these symptoms and not to the same degree (Children's Bureau, 2015). Children are also very resilient and, with proper and individualized assessments and treatment, they can get the help they need to rise above their stressful life circumstances and become healthy and productive adults. The 2011 Child and Family Services Improvement and Innovation Act (P.L. 112-34) requires that States screen for "emotional trauma associated with a child's maltreatment and removal from the home." Such legislation "suggests policy makers recognize that screening for trauma plays a critical role in assisting child welfare systems to meet their goals of safety, permanency, and child well-being" (Sheldon, Tavenner, & Hyde, 2013).

What Are the Behavioral Health Services That Can Address Those Needs?

Medicaid is federal-state partnership that pays for health (including behavioral health) screening, assessment, diagnosis, and treatment services for children and youth identified as low income. The overwhelming majority of children in out-of-home placements in child welfare are Medicaid-eligible recipients. Most children that enter child welfare are eligible for Medicaid and can keep it until they are 26. Among all children who are eligible for Medicaid, less than 10% of the services that are accessed through Medicaid involve behavioral health services. However, these 10% of services account for an estimated 38% of total spending for children in Medicaid (Pires, Grimes, Allen, Gilmer, & Mahadevan, 2013). The high costs are driven by expensive, traditional treatments such as inpatient, residential services, ones in which the children are hospitalized or sent to treatment centers where they stay overnight and often for months or years. These are the types of services that by all measures should be avoided for children involved with the child welfare system to the greatest possible extent. Placements out of family-like homes will exacerbate their existing sensitivities and fears that they are moving around a lot and are forced to yet again sleep in a place that is not their home.

> Children in foster care who access behavioral health services through Medicaid are 7 times more expensive than the general population of children accessing behavioral health services through Medicaid. *Pires, Grimes, Allen Gilmer & Mahadevan, 2013*

Children involved with the child welfare system have complex needs and often are involved with other systems, including juvenile justice, special education and mental health services, even before they enter the child welfare system. A state's behavioral health system must be equipped with professionals who can coordinate the presenting behavior and system complexities and handle each child as an individual. The hope is that every child involved with child welfare can access the help they need to address their grief and healing needs in their current or new community and minimize further placement disruptions. This involves accessing therapies and treatments in the environments where the children spend most of their time, which is at school and their homes. Child welfare agencies also need to support foster parents and staff to find ways to help them understand presenting behaviors and easily access these therapies for children. Models that include treatment with foster families are also very important to consider even if reunification with the biological parents is in progress. Accessible and clinically appropriate services will be of benefit for both the children and their caregivers. An effective behavioral health system should include public and private community providers, including child-trained mental health and substance use treatment professionals. An inclusive approach to developing a network of providers will promote a sense of community in which all providers are working together to serve the children that enter the child welfare system. A diverse pool of providers will enable child welfare agencies to match children with therapists who are skilled in working with histories of complex trauma.

In addition to developing and sustaining a strong and well-trained pool of providers, child welfare administrators need to consider the types of individualized treatment a child needs based on his or her particular strengths, needs, and risk factors. Does a child need to go to traditional once a week therapy or is he or she a better fit with more intensive in-home clinical services? These decisions are not the sole responsibility of the child welfare providers, but should be made in partnership with trained professionals using child-and family-focused screening and assessment tools (*see Resources section for additional information on screening and assessment tools*).

A best practice is for communities to utilize a consistent assessment tool across child- and family-serving systems (Pires & Stroul, 2013). This supports communication and decision-making and provides a common framework to guide child welfare workers and other service providers to make

recommendations to connect a child with therapeutic help. It also has the added advantage of removing the requirement for children and families to repeat their stories to each new professional working with them. Even when a screening or assessment tool is being implemented only within the child welfare agency, it is important to ensure that the tools selected fit with the particular culture, needs, and expertise of each child welfare agency.

In addition to an initial screening by the child welfare worker, when possible, a trained behavioral health professional should assess the social and emotional well-being of the child upon entry into the child welfare system to identify any existing mental health or substance use disorders and make initial recommendations regarding services to support the child. This behavioral health professional will begin the process of assessing the child's functional well-being as well as any medical conditions, stresses, supports, or history that is impacting current health or behavior. The child may not receive a particular diagnosis at this time—and may never require one—but this process will initiate the work of organizing the services and supports that will meet the child's current needs. Some children may need treatment short-term to address current life circumstances and stresses and others may have mental health diagnoses that are long-standing. Early and ongoing identification of this distinction can be critical in choosing the type of interventions that are needed.

Children involved with the child welfare system require the same services that all children served through Medicaid require: high quality, effective services that are available in homes and community settings as well as in traditional clinic-based settings. On occasion, some children and youth will require more intensive, residential treatment, but this should be an option of last resort and only used for short term treatment diagnosis and/or stabilization purposes, and not as a placement option. "Watching and waiting" (i.e., waiting to see if the child demonstrates behaviors requiring intervention) is not the best approach for the child welfare population, since the very fact that they have come into the child welfare system is an experience that is very hard to process on its own.

Behavioral health interventions are not only for school-aged children. Very young children (even age two) and their caregivers (biological and foster) can benefit from early intervention therapy models, including evidence-based programs like Parent-Child Interactive Therapy (PCIT). PCIT uses play as the foundation to address behavioral issues and can effectively be implemented with a foster parent as the caregiver in that role (Children's Bureau, 2013b). If a child can learn to bond with a nurturing adult (even one that is not his or her biological parent), it can promote healthy development.

In reviewing the services that are available to children served through the child welfare system, administrators and workers should seek out (and encourage their Medicaid and other child-serving agency partners to seek out) services that are evidence-based or evidence-informed, particularly for this population. An example of one such intervention is CBT+, which has been demonstrated to yield positive outcomes and includes trauma-focused cognitive behavioral therapy models that are effective with the child welfare population.

SPOTLIGHT ON MASSACHUSETTS

Many of the services and principles described throughout this document are implemented in Massachusetts, which has a system in place to ensure families are getting the right intensity of services. They have defined clinical hubs and a family can get services from one or all of the hubs: outpatient therapy, in-home therapy or intensive care coordination. Each hub-service provider is responsible for collaborating and coordinating care with other service providers that may be working with a family. Information on how MassHealth has designed a continuum of care can be found in *MassHealth Behavioral Health Services for Child and Youth Aged 20 and Younger: A Guide for Staff Who Work with Children, Youth and Families. Children's Behavioral Health Initiative*

What Role Can Medicaid Play to Support the Availability of These Services?

In some states, Medicaid and behavioral health are within the same agency; in other states, they are distinct agencies. In addition to partnering with the behavioral health agency, it is critical to partner with the Medicaid agency in order to sustainably and comprehensively serve children in the child welfare system. Most children that enter child welfare are eligible for Medicaid and can keep that coverage until they are 26 years old. Even when children leave the child welfare system, they often are eligible for Medicaid in their home community. State Medicaid plans have provider networks that include a broad array of services that includes a range of intensity. Closely partnering with Medicaid can help the child welfare agency to expand and sustain the behavioral health services your child welfare children need.

As mentioned above, the financing of Medicaid is a state-federal partnership. Each state receives funds for services paid for eligible individuals on a cost reimbursement basis. This is similar to how child welfare agencies receive traditional Title IV-E funds under the Social Security Act. These IV-E funds are used to ensure the safety and well-being of children in a state's care and custody. However, IV-E federal funds cannot be used to meet a child's physical and behavioral health needs (Medicaid and CHIP Payment and Access Commission, 2015).

Medicaid is the most consistent, comprehensive, and sustainable financing mechanism to meet the behavioral health needs of children involved with the child welfare system and needs to be prioritized to support long-term access to home- and community-based behavioral health services. State Medicaid authorities partner with state child welfare directors to pay for services through a variety of different methods. Each state is different in how it chooses to provide services (including whether it is a managed care state and what the managed care arrangement looks like) and how widely they make the services available.

SPOTLIGHT ON NEW JERSEY

New Jersey uses a braided funding model that includes child welfare funding to make sure that services are available to all children in the state, regardless of whether they are in child welfare or have Medicaid. The following highlights of the New Jersey model is from Pires & Stroul (2013).

- Customized child behavioral health carve-out using blended funds, Medicaid as administrative single payer system and DCF with management oversight
- Coverage of intensive care coordination at low ratios using high-quality wraparound and care management organizations for children with complex behavioral health needs
- Payment for family and youth peer support using Medicaid administrative dollars
- Coverage of broad array of home- and community-based services using the Rehab Services Option
- Maximization of Medicaid by using child welfare, behavioral health and Medicaid dollars to expand federal match
- Health units in child welfare financed with Medicaid administrative dollars
- Requirement for designated care coordinators in Medicaid HMOs as liaisons to child welfare
- Payment for behavioral health clinical consultation to local child welfare offices
- Enhanced Medicaid rate for physical and behavioral screens within 30 days of placement
- Training of Medicaid providers in evidence-based practices and in the child welfare population
- Tracking data indicators specific to the child welfare population & d review of psychotropic medications through data sharing between child welfare and Medicaid

The child welfare system sometimes provides services to children as part of a voluntary placement agreement or as a result of custody relinquishment when families are unable to access needed behavioral health services through their commercial insurance or if they are uninsured. In some places, such as New Jersey, all children

have access to the same services regardless of whether they receive Medicaid; if their commercial insurance does not cover the service, the state will pay for the service as a "Medicaid look-alike." This avoids the traumatic experience of having a child come into foster care solely to receive access to services. The more that the child welfare agency is able to partner with the Medicaid agency to make services available to everyone (regardless of insurance), the lower the burden on the child welfare agency.

Most states have some form of managed care structure in place and many children in foster care receive some or all of their Medicaid services through a managed care organization. The process of service discussions will be different in various states depending on whether the child welfare agency needs to collaborate with one or multiple managed care organizations or directly with the Medicaid authority. Additionally, in some states, Medicaid behavioral health services are overseen by the behavioral health authority through an agreement with Medicaid. These nuances will drive how child welfare agencies approach creating stronger partnerships with Medicaid authorities to best meet the needs of their child welfare youth to leverage and advance child welfare specific initiatives.

There are four big rules that child welfare administrators need to keep in mind in order to enable a child in foster care to access Medicaid's services:

- The child must be eligible and enrolled in Medicaid;
- The service the child is accessing must be a covered and reimbursable service by Medicaid and included in a state's Medicaid State Plan;
- The provider rendering the service must be an actively participating Medicaid provider, credentialed and licensed according to respective state laws, able to provide the service to the child in accordance with the Medicaid State Plan; and,
- The child must meet medical necessity criteria for a particular service.

Medical need for each service is outlined through medical necessity criteria (MNC) to ensure youth receive the most appropriate and least restrictive services. This process assists with determining whether the service that is recommended can provide the intensity, frequency and duration of treatment to address and treat the identified disorder or problem. States often require providers to receive pre-authorization from the managed care company or administrative service organization, which acts as a gateway to control the utilization and cost of the service to a state.

MNC create a mechanism to make services available to those that seriously and medically need it and can benefit from the treatment. Social service agencies, which include child welfare agencies, may base resource decisions on identified social and environmental needs, which may not always align with the MNC for a particular service. One way that some states address this issue is by developing a service array that is available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid (Mann, 2013; Sheldon, Tavenner, & Hyde, 2013). Under

SPOTLIGHT ON CALIFORNIA

California is a county-run child welfare and mental health authority system. In part as the result of a class action lawsuit known as Katie A. (Katie A. v. Bonta), children and youth involved with child welfare who have more intensive needs now have access to intensive care coordination, intensive home based services, and therapeutic foster care.

The Katie A Core Practice Model (available from http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf) articulates how the county child welfare and mental health systems are expected to interact with each other in support of the child and family and the types of services that are available to support them.

EPSDT, children can access services and treatment based on a need that is identified through screening and assessment; this supports early intervention and treatment rather than necessitating a particular diagnosis that is required to have been experienced for a particular duration as may be required through MNC. Although child welfare agencies can attempt to access services for children through the EPSDT benefit based on a need identified through screening and assessment, if the service array has not been developed, there may not be a clear mechanism by which to access the service—or even a provider who can offer the intervention.

There also are implications for accessing services if children involved with child welfare are receiving Medicaid prior to coming into foster care. Child welfare directors can partner with Medicaid agencies to identify opportunities to promote continuity of care with community providers, including through streamlined Medicaid eligibility re-determination processes when a child is reunified. When placing a child in a new foster care placement there are many considerations; one of them should be whether a child currently is engaged in mental health treatment and to avoid disrupting this relationship if at all possible.

What Steps Can I Consider Next?

As child welfare leaders engage with their Medicaid and behavioral health colleagues to develop and implement services and interventions under Medicaid, it is critical that they are cognizant of contextual and historical factors. For example, a Medicaid agency may be reluctant to carve-out services for specific populations based on a current movement toward integrated managed care or because the agency is concerned that children will receive specialized services while in foster care but will not have continuity of care when they reunify with their families. Alternatively, the Medicaid agency may be concerned about the source of the state matching funds for services that are expanded, therefore, will serve all eligible children, not just those involved with the child welfare system.

Similarly, child welfare leaders should be aware of what has been successful in other states and how challenges such as issues of "statewideness" and "family of one" have been handled in various contexts. It is critical to have data that explore utilization patterns and outline which services children in the child welfare system are accessing; they may be accessing some of Medicaid's most expensive (and restrictive) services, and a shift to more home- and community-based services could save the state money in the end as well as improving outcomes.

Immediate next steps will depend on whether the child welfare agency is state- or county-run and the nature of existing partnerships with Medicaid and other agencies. Additionally, administrators will need to consider the impact of other related policy and financing issues, including whether there are any current lawsuits or settlement agreements, if the state is a Medicaid-expansion state, and if there is a Title IV-E Waiver in place. They also need to know about the current relationship with the regional office of the Centers for Medicare & Medicaid Services (CMS) and what guidance has been received from that office in response to recent modifications to the Medicaid State Plan. There are examples across the country of partnerships between child welfare and Medicaid agencies that have expanded access to diagnosis, screening, assessment and treatment services that have been mutually beneficial to both agencies, as well as to the children and families served. These states have State Plan Amendments that can be reviewed as well as MNC, service definitions, service rates, and billing codes, all of which can be used as a foundation for justifying expansion of Medicaid covered services to meet the needs of the child welfare population. Since Medicaid is a state run program, with federal oversight, states have incredible flexibility to design services to meet their state's service needs.

While financing mechanisms are being established, child welfare leaders need to be at the tables that are developing and implementing comprehensive home- and community-based service arrays to ensure that they are accessible to families involved with the child welfare system. Some of the key services and supports that should be available in every state and community to children and youth with behavioral health, including those in the child welfare system, include:

- Individualized, intensive care coordination
- Mobile Crisis Response and Stabilization
- Intensive In-Home Services/Therapies
- Family and Youth Peer Support
- Respite Care
- Medication Management and Psychotropic Medication Review Protocols
- Psychiatric Consultation to Health Care Professionals
- Evidence-based and promising practices

It is important to remember that medical necessity criteria can be defined broadly to meet the needs of children and youth who may have experienced significant trauma, but who may not meet a narrow definition of SED (seriously emotionally disturbed or serious emotional disability), which often has been part of the criteria used in the past.

More information and resources about each of these services can be found in the appendix. Additionally, the appendix contains links to numerous resources including examples of medical necessity criteria and program specifications, issue briefs and guides, and federal policy guidance.

There are many pathways to move the work forward and ensure that children involved with the child welfare system have improved access to high quality and effective community-based services and supports. The information contained in this brief is meant to be a starting point for this critically important work to support some of our most vulnerable children, youth and families.

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Appendices

State-Specific Medical Necessity Criteria & Service Guidelines

California (County-Run System):

- *Pathways to Mental Health Services: Core Practice Model* (CPM) Guide: http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf
- *Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Base Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members:* http://www.dhcs.ca.gov/services/MH/Documents/ICC_IHBS_TFC_manual.pdf

Massachusetts (State-Run System):

- *MassHealth Behavioral Health Services for Child and Youth Aged 20 and Younger: A Guide for Staff Who Work with Children, Youth and Families. Children's Behavioral Health Initiative:* http://www.mass.gov/eohhs/docs/masshealth/cbhi/cbhi-guide.pdf
- Targeted Case Management: Intensive Care Coordination
    - Performance Specifications: http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-tcm-icc-ps.pdf
    - Medical Necessity Criteria
    - State Plan Amendment: http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-target-case-mgt-services-icc.pdf http://media.wix.com/ugd/6461c5_0a06f54f99684402b4b5ee5d1dbf0127.pdf
- In Home Therapy
    - Performance Specifications: http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-in-home-therapy.pdf
    - Medical Necessity Criteria: http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-in-home-therapy-services.pdf
- Mobile Crisis
    - Performance Specifications: http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-mobile-crisis-intervention.pdf
    - Medical Necessity Criteria: http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-mobile-crisis-intervention.pdf

Milwaukee, Wisconsin (County-Run System):

- Wraparound Milwaukee Provider Practice Guidelines: http://wraparoundmke.com/provider-network-2/provider-practice-guidelines/
- Wisconsin Emergency Mental Health Service Programs (i.e. crisis benefit): https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/34

New Jersey (State-Run System):

- Care Management Organization Service Guidelines:
    - Moderate: http://www.performcarenj.org/pdf/provider/clinicalcriteria/cmo-moderate.pdf
    - High: http://www.performcarenj.org/pdf/provider/clinicalcriteria/cmo-high.pdf
- Contracted System Administrator for the Children's System of Care: http://www.state.nj.us/treasury/purchase/noa/contracts/t1932_09-x-20037.shtml
- Division of Medical Assistance and Health Services Case Management Service Manual: http://www.state.nj.us/humanservices/dmahs/info/resources/manuals/10-73_Manual.pdf

- PerformCare Provider Service Code Guidelines: http://www.performcarenj.org/pdf/provider/prov-service-code-guidelines.pdf

Other Resources

- *Children's Faces of Medicaid* Resources: http://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

- *Customizing Health Homes for Children with Severe Behavioral Health Challenges:* http://media.wix.com/ugd/6461c5_9bfb750fcc7c432787898bac30877bef.pdf

- *Developing a Trauma-Informed Child Welfare System:* https://www.childwelfare.gov/pubs/issue-briefs/trauma-informed

- *Intensive Care Coordination Using High Quality Wraparound: Rates and Billing Structure*: http://www.chcs.org/media/Intensive-Care-Coordination-Using-Wraparound_Rates-and-Billing-Structure.pdf

- *Long-Term Consequences of Child Abuse and Neglect:* https://www.childwalfare.gov/pubs/factsheets/long-term-consequences

- *Medicaid and Children in Foster Care:* http://www.childwelfaresparc.files.wordpress.com/2013/03/medicaid-and-children-in-foster-care.pdf

- *Report to Congress on Medicaid and CHIP. Chapter 3: The Intersection of Medicaid and Child Welfare:* https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf

- *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles:* http://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf

- *Making Medicaid Work for Children in Child Welfare*: *Examples from the Field*: http://www.chcs.org/media/Making_Medicaid_Work.pdf

- *Assessment Tools* (*Nb.* Tools are provided for reference only. significant consideration should be given to selecting a tool that will serve the identified purpose, is culturally and linguistically appropriate, is a good fit with the workforce and the population, and can be implemented and maintained at a necessary scale. Inclusion of the tools below should not be construed as endorsement.)
    - Child and Adolescent Needs and Strengths (CANS): http://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/
    - TOP Assessment: http://kidsinsight.org/how-we-help/top-assessment/

Federal Informational Bulletins

Joint Informational Bulletin
SUBJECT: Coverage of Early Intervention Services for First Episode Psychosis (10/16/15)
http://medicaid.gov/federal-policy-guidance/downloads/CIB-10-16-2015.pdf

State Medical Director Letter
SUBJECT: New Service Delivery Opportunities for Individuals with Substance Use Disorder (7/27/15)
http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

Joint CMCS and SAMHSA Informational Bulletin
SUBJECT: Coverage of Behavioral Health Services for Youth with Substance Use Disorders (1/26/15)
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf

CMCS Informational Bulletin
SUBJECT: Delivery Opportunities for Individuals with a Substance Use Disorder (10/29/14)
http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-10-29-14.pdf

CMCS Informational Bulletin
SUBJECT: Clarification of Medicaid Coverage of Services to Children with Autism (7/7/14)
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

CMCS Informational Bulletin
SUBJECT: Update on Preventive Services Initiatives (11/27/13)
http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf

Tri-Agency Letter
SUBJECT: Trauma-Informed Treatment (7/11/13)
http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

Joint CMS and SAMHSA Informational Bulletin
SUBJECT: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (5/7/13)
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

CMCS Informational Bulletin
SUBJECT: Prevention and Early Identification of Mental Health and Substance Use Conditions (3/27/13)
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf

CMCS Informational Bulletin
SUBJECT: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations (8/24/12)
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-24-12.pdf

CMCS Informational Bulletin
SUBJECT: Coverage & Service Design Opportunities for Individuals with Mental Illness & Substance Use Disorders (12/3/12)
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

ACF Informational Bulletin
SUBJECT: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services (4/17/12)
http://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf

Tri-Agency Letter
SUBJECT: Appropriate Use of Psychotropic Medications Among Children in Foster Care (11/23/11)
http://www.medicaid.gov/federal-policy-guidance/downloads/SMD-11-23-11.pdf